Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 5:47 A M Oct 15. Franklin H. Weaver Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9108 Ballard Lane Prince George's Clinton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** X X 2 - F Months Days Hours Min (Month, Day, Jarch 22 86 Washington DC **Director** 579 22 9188 1925 March Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 XXNo Maryland Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9108 Ballard Lane 20735 United States death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. "natural", or ģ 1 Never Married 2 X Married 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Divorced 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Thompsons Honor Dairy 12 Milk Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harry Bates Weaver Edith Pearl Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Ann Weaver (Wife) 9108 Ballard Lane, Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Maryland Veterans Cemetery 10/20/2011 Cheltenham, MD 21. Sign vure of Funeral Service Licens 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria M01555 Ferry Road, Clinton, MD 20735 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBROVASCULAR Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death 2 No the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MELLITUS 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performer 1 Yes 2 No Yes 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural injury 5 Pending after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

10+1 DC State

DHMH 17 Rev 7/2009

Registrar

29b. Signature a

31. Date filed (Month, Day, Year)

nd title of certifier

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

AMANAN

057 Office

29c. License number

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warport mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** OCT. 201°1 12 MCKELLER MAE WALKER 7:04AM M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL If Under 1 Year If Under 24 His. 8. Date of Birth
Months Days Hours Min. (Month, Day,
MARCH 14 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** ^{Yea} 1931 Country) 1 □ M 2X F 80 247 86 1617 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director 1√PYes 2 □ No WASHINGTON D.C. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 1368 MERIDIAN PLACE N.W. 20010 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11 Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify. Completed by Specify: BLACK 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental H BRANTLEY WALKER LELIA WIGGINS ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20623 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: if item 27 Is any injury or other trau once. 10108 GARDEN VALLEY CT. CHELTENHAM MD. DAVID WALKER/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Dopation 5 Dother (Specify) SAVANNAH CREEK CEM. 10/22/11 EHRHARDT, S.C. of Funeral Service Licensee 21. Signature 22. Name and Address of Facility 20010 a WATSON FH 3435 14th ST. NW WASH. Part 1. By ter the disease, or complications that call sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as Examiner moh Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (dr as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) nding physician a Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 2 1 MG P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 7 Inknown Be Completed 24b. Were autopsy findings available prior to completion of ause of death? 24a. Was an autopsy performed? 1 ☐Yes 2 No 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manur of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 24 hours after death.

To the Funeral Director: After th.

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of continer

30, Name and address of person who completed cause of death (Item

Year

License number

29d. Date signed (Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 For State Registrar 35003 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October 12, Physician/ 201^{Tear} 4:00 Ρ Melvin Arnold Waldstein Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Montgomery 2322 Arthur Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 075-16-1357 Director 1 X M 2 D F 90 Yrs 06/07/1921 NY Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD 1X Yes 2 ☐ No Montgomery Silver Spring 10e. Street and Numbe 10f. Zip Code r items 23a or ner must be n ö 10g. Citizen of What Country? Funeral 20902 2322 Arthur Avenue USA death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? 1 X Yes 2 □ No WWII Black, White, etc. ō 1 Never Married 2 X Married Š Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 'natural", Completed 3 Widowed 4 Divorced Specify: White the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Wine Sales Retail other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F 2 Charles Waldstein Fay Gunty Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Helen Z Waldstein - Wife 2322 Arthur Avenue Silver Spring MD 20902 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) King David Memorial Gardens 4 ☐ Donation 5 ☐ Other (Specify) Falls Church, VA 10/16/2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockvill Pike. Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Brain Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying social transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death be detached 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 V Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No 1 ☐ Yes 2 🛣 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita Other: ပု 1 Yes 2 X No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 K Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural 5 Pending within 24 hours are death. To the Funeral Director A 2 🗌 No the Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ompletely 3 Ecertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

Registrar

Kuprisan chis

1 8 2011

Katherine Kemper-Dean,

31. Date filed (Month, Day, Year

OCT

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signar

F089866

C.R.N.P. 18121 Georgia Avenue Suite 103 Olney, MD 20832

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** EDITH M. ZENTZ 3:50P Oct. 2011 21, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 2525 Mountain Road Harford Joppa 9. Birthplace (State or Foreign Country)
Tenn. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12/15/1922 Social Security Number 7. Age (In vrs. last birthday **Funeral** Min. Days Hours Months 254-30-4555 88 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Exercitor must be notified at Director 1 ☐ Yes 2 📉 No MD Harford Joppa 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2525 Mountain Road 21085 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 Tes 2 Yes 1 Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: Specify: White δ ¥☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Floor Manager ġ 27 is marked other ar traumatic event, ■ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 1 nent of Health and Mental Levi Pell Ella Mae Holden 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2525 Mountain Road, Joppa, MD Evelyn Ryan/Daughter Department of Health Important: If item 27 any injury or other troops 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) st. John Cemetery 10/25/11 Westminster, MD 21. Signature of Funeral Service 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) · /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner lany leading to Immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed 0+0/47 burial-tran Due to (or as consequence of) Division of Vital Records, P.O. Box 68760, the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ρ Month Year 5 Other (specify) the detached 9 Unknown à signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed or Attending Physician: The certificate 1 ☐ Yes 2 🖼 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide Hospital within 24 hours a Medical 29a, Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (1 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35005 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCT ONG BUN AN 0938 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min M2nth 294- 1931 Courtorea **Director** 450-65-6386 80.4 Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location notified at Director 28a-f 1 Yes X No Ellicott City MD Howard 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? rms 23a or Funeral Korea 21043 8002 Brightlight Place Health and Mental Hygiene "tatural", or items ten 27 is marked other than "natural", or items other traumatic event, the Mudical Examiner m. permit. Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 X Widowed 4 Divorced Asian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Church Pastor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jung Eunhee Sayoung Jung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8002 Brightlight Place, Ellicott City, MD 21043 Department of Health Important: If item 27 any injury or other tr Hae Ri - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place Meadowridge Mem Park 11-03-2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at 21. Signature of Funeral Service Inc, 7250 Wash Blvd, Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Du to (or as a consequence of) hour disease or condition resulting in death) Medical Examiner Sequentially list conditions, Due to for as a consequence off if any leading to immedicause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director, After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HYPERTENSION DIABETES MELLITUS 1 Yes 2 No 3 Probably 4 Unknown should should INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy in by the funeral director, page 2 After this certificate 2 🗆 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No Certificate: 28d. Describe how injury occurred ■ Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital on within 24 hours aff To the Funeral Discompleted filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar dec in

Benjamin S.
31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m.D

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GRETTE

Physician

32. Registrar's Signature

D52544

Pd #204, Catonsville, MD

			Please	Type or Print in Blac	k Inde, lible 1 nk 1 Fnsy Pepartment of Health 3 Certificate of Death	re All Copies A	re Legible	•
			1 - For State Registrar	amend' l'iem#5pér	FR, 6946, 12/472013 Certificate of Death	, WS Reg.	No. 201	1 25000
	Physicia Medic		1. Decedent's Name (First, Middle, Last		•	2 Date of Death	Day 2 Year 30	3, Time of Death
	Examir	er	4a. Facility Name (if not institution, give s Loch Raven Commu		4b. City, Town, or Location of	Death	4c. County of Dea	th
	Funeral Director		5. Social Security Num 342 6. Se 218 - 07 - 3347 15	ZM 2 DE		Hrs. 8. Date of Birth Min. (Month Day, Yea	921 N	rthplace (State or Foreign
	Maryland 28a-f show etified at	Director	10a. State 10b. County	ord Doc	or Location			10d. Inside City Limits
	with the 23a or 2	Funeral Di	10e. Street and Number	1 Samore	10f. Zip Code 2/015	10g.	Citizen of What Co	ountry?
9036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland cartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 8a.	ě	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decellent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☑ No If Yes, Give Year or Dates.	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F. 1 Yes 2 No Specify:	? (Specify Yes or No-	14. Race - Ame Black, Whit	
21215-0036	iled within 72 hou I Hygiene other than "natu rent, <u>the Medica</u>	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Seconday (0-12)		Decedent's Usual Occupation (Give kind of work done during most of the DO NOT use retired)	f working	Kind of Business	_
Maryland	ild be filed Mental Hy iarked oth atic event	To Be	17. Father's Name (First, Middle, Last)	itton	18. Mother's	Name (First, Middle, Maid	en Strname)	Ω
	and 2 should Health and M tem 27 is mar ther traumat		19a. Informant's Name/Relationship (Type	e, frinDurghter) 19b	Mailing Address (Street and Number of Action 1)	or Rural Route Number, City	or Town, State, Zi	p Code) MD 2/015
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Balt	permit. Page Department of Important: It any injury or once.	ļį	21. Signature of Funeral Service License	on MOIB36	22 Name and dress of Fully	ens Types	al Ser	ريعان
_	nysician/ Medical		23a. Part 1. Enter the deease, or compleshock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	Cancer	diac or respiratory arrest,	2/0/	Approximate Interval Between Onset and Death
لمسا	Examiner	<u>. </u>	Sequentially list conditions,	Due to (or as a consequence o	rf):			
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	0 2 2		resulting in death) Last	Due to (or as a consequence o	f):			-
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should the detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year
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Records,	sician: The law re certificate has be irector, page 2 sho	Completed			-	24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
<u>ta</u>	ysician: is certific director,	Be	25. Was case referred to medical examiner?	ospital:	26. Place of Death (1
ot <	g Phys er this eral dir	<u>ရ</u>	27. Manner of Death	1 Inpatient 2 ER/Out 28a. Date of injury 28b. Ti	me of 28c, Injury at	ng Home 5 Residence 28d. Describe how in		HOSPICE
on o	eath. or: After the funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Year) in	jury work? M 1 ☐ Yes 2 ☐ No		ary occurred	
Division of Vital	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the		4 Homicide determined	28e. Place of Injury - At home, fan building, etc. (Specify)		28f. Location (Street City or Town, Sta	ite)	
	the Hosp hin 24 ho the Fune npleted fi	Medical	only one 3 Certifying Nurse	r: On the basis of examination and/or	eath occured at the time, date and place investigation, in my opinion, death occur dgn. draft annunct at the firme date an	red at the time, date and also	ce and due to the	cause(s) and manner stated
	0 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1 × 1		29b. Signature and title of certifier Auva C	. With to	M.D. 29c. License number 5	29d. I	to ber	30, Day, Year) 2011
	(H)		30. Name and address of person who con	npleted cause of death (Item 23a) (T	ype, Print) 3900 Local Baltim	ove, Mai	Soular	21218
	State Registra	_	31. Date filed (Month, Day, Year)	32. Registrar's Signature	>			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Betty Andreadakis October 31 10:35 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Timonium Baltimore . Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 234-26-9373 Months Days **Director** 1 □ M 2XX F 90 West Virginia Yrs. October 15,1921 Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Lutherville 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be I Funeral 515 Brightfield Road 21093 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 XX Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 ₩Widowed 4 □ Divorced If Yes, Give Specify: White Completed Year or Dates 10:35 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 31, 2011 2 Department of Health and Ment. Important: If item 27 is marked any injury or other treasmen. Ernest Zades Mary Carmichal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Andreadakis (Son) 8310 Tally Ho Road Lutherville, MD 21093 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date CTOBER Greek Or chematory of other place) 11/3/2011 Baltimore, MD Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home. Inc. 3631 Falls Road Balto, MD 21211 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy Live Birth 2 Fetal death BETTY ANDREADAKIS 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 📉 No Dav Month Year Pregnant at time of death 5 Other (specify) be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes director, page 2 should Completed Hospital or Attending Physician: The law requii 24 hours after death. Funeral Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \undextbf{X} Other (Specify) **HOSPICE** 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending 2 🗆 No 2 Accident 3 Suicide 4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

e Funeral I

within 2 To the I

Medical

29a. Certifie

(Check

only one 29b. Signature and

JACKIE JONES,

DHMH 17 Rev 06-2011

State Registrar 2300 DULANEY VALLEY RD.

of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. The certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

011

29c. License number

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	01	,	Decedent's Name (First, Middentification)								2. Date of Dea	ath		3. Time of Death
	Physicia Medic	al	Lawrence Al								March :	26, Day	2011 Year	21:25 P ^M
	Examin	er	4a. Facility Name (if not institution Southern Mary				4b. City, To			of Death		4c.	County of Death	
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	llin Year	If Under		8. Date of Birt	th	PG 9. Birth	place (State or Foreign
	Director		579-52-4004	1 X M 2 □ F	70	Yrs.	Months	Days	Hours	Min.	12/9/19	y, Year) 940	_Gec	orgia
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	farylar 3a-f sl	Director	DC			Washin								1 🏹 Yes 2 □ No
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уlаı	ild be Menta narked latic e	욘	Albert Bates						E]	lla E	roadna	X		
Maryland	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relation Raymond Bates			1						. ,	Town, State, Zip	Code) 20782
	I and 2 s F Health Item 27		20a. Method of Disposition	- broaler	20b.	Place of Dispo	sition (Name	of	- :		ate Inyac		ocation - City or	
E O			1 🔀 Burial 2 🗌 Crematio 4 🗎 Donation 5 🔲 Other			cemetery, cren 11MONY			9 4	1/4/2	011	Land	dover, M	Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signstura of Funeral Service	Licensee	.0								l Servic	es
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			23a. Part 1 Enter the disease, should, or heart failure. Lis Immediate Cause (Final	or complications that really one cause on e	ach line.	ith. Do not ente		_	~				20	Approximate Interval Between Onset and Death
	Ph, sician/ Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):	and	LLE		lee.	owsa	Xer I.	Usan	Mondon
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并 Division of Vital Record	al or A s after I Direc d in by		4 ☐ Homicide deter		e of Injury - At h ling, etc. (Specif		eet, factory, t	Jilice			City or Tov			al Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending pl completed filled in by the funeral director, page 2 should be detached for use as t	Medical	29a. Certifier 1 Certifyii (Check 2 Medica	ng Physician: To the la	best of my knov	vledge, death o	occured at th	ie time,	date and	place, an	d due to the ca	ause(s) ar	nd manner as sta	ted. ause(s) and manner stated.
	the H thin 24 the F	Me		ng Nurse Practioner:			death occurre	d at the	time, date			ne cause(s) and manner as	stated.
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			30. Name and address of perso	n who completed cau	se of death (Iter	m 23a) (Type, F	Print)	0	7		l'		1.	1 2011
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Registrar

Registrar Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ OCTOBER 19 2011 3:47 P M **JOSHUA** ILYA BEZMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2115 HARMONY WOODS ROAD BALTIMORE OWINGS MILLS If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours 1 🛚 M 2 🗆 F 212-21-9401 Director 37 04/07/1974 RUSSIA Usual Residence of Decede ian "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2115 HARMONY WOODS ROAD 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black White etc. 1 Never Married 2 Married þ Maryland 21215-0036 WHITE If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) event, the 12 NONE NONE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev MICHAEL BEZMAN LENA **GELFAND** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2115 HARMONY WOODS ROAD, OWINGS MILLS, MD MICHAEL BEZMAN/FATHER Báltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 10/24/2011 TOWSON, MD 21. Signature of Funeral Service Lio 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Lett 8900 REISTERSTOWN ROAD, PIKESVILLE 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Inset and Death disorder eizure Physician years disease or condition resulting in death) Medical Due to (or as a consequence of **Encephalopathy** 20 years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami CERTIFICATION APPROVED BY MEDICAL EXAM that the death certificate be executed burial-trar and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical P.O. Box 68760 the nding ' use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atten for u in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death
Unknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records. 1 Yes 2. No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 \(\sum \) Nursing Home 5 Residence 6 \(\sum \) Other (Specify) မ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? I Director; After to d in by the funera 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a

To the Funeral C

completely filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

Ludeltwaln 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

> 1734 32. Registrar's Signature

51454 October 20, 2011 Lutherille, MD 21093

0051454

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28. 201 I Joseph Bellavia 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's 12002 N. Marlton Avenue Upper Marlboro 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 1 🕅 M 2 □ F 9. Birthplace (State or Foreign **Funeral** Hours May 24, Yan 1919 Italy 92 Director 032-03-3115 Usual Residence of Decedent shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 28a-f 1 X Yes 2 ☐ No Maryland Prince George's Upper Marlboro ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 12002 N. Marlton Avenue 20772 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or ρ 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Engineering 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Francesco Bellavia Crocefissa Garufo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) 12002 N. Marlton Ave., Upper Marlboro, MD 20772 Annmarie Lannin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State Forest Glade Cemetery 11/9/2011 Wakefield, MA 4 Donation 5 Other (Specify) 21. Signature of Huneral Service Lix ns 22. Name and Address of Facility
McDonald Funeral Home
19 Yale Ave., Wakefield, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cevelus vasa vlas disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Cevelus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) sician and burial-transit iuyelo nvoli Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical rear certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Hospital or Attending Physician: The law requires that the death in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 KNO signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cevehovasila Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' certificate Yes 2 No 1 ☐ Yes 2 ☐ No To the Prospine.

Within 24 hours after death.

To the Funeral Director. After this certifice. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🕅 Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

IDV State

DHMH 17 Flav 7/2009

Registrar

Medical

29a. Certifier

Alain 31. Date filed (Month, Day,

29b. Signature and title of certif

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

hampaloup MD

🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieneth

		1- For State AMED Registrar	d #4bPer PH	Certific	cate of De	eath	11/(03/20	II JII R	eg. No.	201	1 3501
Physiciai Medical Examin		1. Decedent's Name (First, Middle,Las Michael Alan	Belch						Date of Dea Month October 2	ith Day	Year 1	3. Time of Death 1925 hrs
		 Facility Name (if not institution, giv 7368 Kindler Road 	e street and number)			ity, Town, or licott City -		of Death umbia	ı		County of Death oward	
Funeral Director		5. Social Security Number 6. Sr 246-92-1401	7. Age (I M 2 F	n yrs. last bir		Under 1 Yea	_		B. Date of Bi	rth (MM/D	1953 Foreig	hplace (State or n RI
Maryland 28a-fahow any datonce.	<u>ا</u>	Usual Residence of Decedent 10a. State 10b. County MD Howard	10	c. City, Towr	or Location	ity C	o1umb	ia				10d. Inside City Limits 1 Yes 2 X No
with the Maryland ns 23a or 28a-f sho be notified at once	I Director	10e. Street and Number 7368 Kindler Ro	ad			Zip Code 21046			1		en of What Cour USA	try?
after death wit ni", or items 2 ner must be n	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev. Armed Forces? 1 Yes 2 X			cedent of His becify Cuban 2 X No	, Mexican,	in? (Specii Puerto Ric	fy Yes or No an, etc.)		can Indian, Black, te	
2 hour	Completed	15. Decedent's Education (Specify or Elementary/Secondary (0-12)	College (1-4 or 5+)		Decedent's Us during most of nformat	working life.	DO NOT	use retired)			nd of Business/II	•
21215-0036 Juld be filed within 7 Mental Hygiene. Marked other than ic event, the Medica	<u> </u>	17. Father's Name (First, Middle, Last) Charles Hogle B	elch Jr.				Inez	Shepa				
MD 21 nd 2 should alth and Me m 27 is ma	-	19a. Informant's Name/Relationship (T Sherry Johnston (1	b. Mailing Add 1996 La of Disposition (ndover	Dr.,	, Cler	nmons,	NC		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and N Important: If item 271 is in injury or other traumatic.	1	20a. Method of Disposition 1 Burial 2 Cremation 3 [4 Donation 5 Other Specify. 21 Signature of Funeral Service Licen	esville Home &	, MD								
m	4	Pararofaratto 23a. Part I. Enter the disease, or comp	1784									
/Medical Examiner	1	failure. List only one cause on ea	ch line. Atherosclerotic Ca Due to (or as a conseque	rdiovascu			3401 83 02	TOTAL OF THE	spiratory arri	est, siloci	x, or neart	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): C. Due to (or as a consequence of):										
760, icate be executed physician and the burial - transit		events resulting in death) Last d. UNPENDED	Oue to (or as a conseque	ence of):								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transi	nysician,	FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	e of death	Fetal de	Specify)		pregnancy		1	Date of delivery flonth D	ay Year
S, P.O. Lires that the a signed by d be detach	3	Part II. Other significant conditions	contributing to death bu	t not resulting	g in the underly	ving cause gi	iven in Parl	t I.		_		ne cause of death?
	on blefed	25. Was case referred to medical				26 Place	of Doath (C	Check only	24a. Was a autop perfor	sy m <u>ed</u> ?		opsy findings available empletion of cause of 2 No
f Vital Physician or this cert ral director	וֹ מֿ		ospital: 1 Inpatient	2 ER/O	utpatient 3			Nursing Ho		Residenc	ce 6 🗸 Other:	Scene
Division of spital or Attending P hours after death. neral Director: After filled in by the funeral former of the former of the funeral former filled in by the funeral former f	auon.	27 Managed Death										
Division To the Hospital or Attent within 24 bours after death To the Foureral Director: completely filled in by the												- V-2011
To the Ho within 24 F. To the Fun completely	200	one) 2 Medical Examiner:	In: To the best of my kn On the basis of examina and manner stated.	owledge, dea ition and/or in	ath occurred at nvestigation, in	the time, dat my opinion,	te and plac death occu	e, and due urred at the	to the cause time, date a	e(s) and r and place	manner as state	d. cause(s)
	E	29b. Signature and title of certifier		29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 28, 2011							th, Day, Year)	
	3	30. Name and address of person who c Ling Li, MD Assistant Me	ompleted cause of death edical Examiner		altimore St	reet, Baltí	more, M	D 21223	3			
Stat Registra		11. Date filed (Month, Day, Year) NOV 0.3 2011	32. Registrar's S	ignature	arket.							

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			For State	State of N	/laryland		rtment of l		and Ment		2.0		35012		
			Registrar 1. Decedent's Name (First, Middle, L	ast)		Cert	meate or i	Death		ate of Deat		1 1	3. Time of Death		
	Physicia Medic		Doris A	. Bolt	on				0°C	_{lonth} tober	Day 31	Year 2011	05:15 A ^M		
other (Examin		4a. Facility Name (if not institution, gi				4b. City, Town, o	or Location of	of Death		4c. County	•			
Sec.	-		Morningside Hous 5. Social Security Number 6.		d Livi		If Under 1 Year	Ianove If Under		ate of Birth			rundel place (State or Foreign		
100	Funeral Director	1 1	218-18-4913	1 M 2 X F	87	Yrs.	Months Days		Min. (N	fonth, Day,	Year)	Cou	ntry)		
	, Mo		Usual Residence of Decedent 10a, State 10b. County			Town or Loc			Se	pt. 2	3 1924		MD		
	arylanda-f sh ied a	Director		7 7 7	1		аноп						10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
	the Ma or 28	Ö	Maryland Anne 10e. Street and Number	Arundel	bal	timore	10f. Zip Code			1	I 0g. Citizen of	What Cou	untry?		
	s 23a	Funeral	202 Greenland	Beach Rao	đ		212	226			USA				
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1	t Ever in U.S. ? X No		as Decedent of H Yes, specify Cub			es or No- , etc.)		ck, White,	ican Indian, , etc. White		
2-0	hour 'natur	olete	15. Decedent's (Specify only highest	Education		16a. Decede	ent's Usual Occu	pation	t of working		16b. Kind of E	3usiness/li	ndustry		
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/an	should and h is ma		19a. Informant's Name/Relationship			4	Address (Street				-				
e,	and 2 Health em 27 ther tr		Linda M. Muzik 20a. Method of Disposition	(daughte			N. Ferry	, Poin							
Baltimore, Maryland 21215-0036	age 1 ent of I nt: If it		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		te ce	metery, crem	ition (Name of atory or other pla en Cemet	ce)	Nov. 0 2011	5	20c. Location	•	e, Maryland		
altir	permit. P Departmo Importar any injur once,		21. Signature of Funera vervice Vice	A	1 919		Name and Addre	2					Home, P.A.		
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	Physician) Medical		23a. Part 1. Enter the disease, or co shock, or heart fature. List only Immediate Cause (Final disease or condition resulting in death)	orle cause orlead li	ed the death. ine. ine ine.	19	the mode of dyi	ng, such as	cardiac or resp	oiratory arre	est,		Approximate Interval Between Onset and Death		
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2	ed	Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):											
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687	eath certificat attending ph d for use as th	Physician/Me	IF FEMALE:	23c. If yes, outcom	ne of pregnan	cv					004.0	-45 -1-1			
XO	attene attened for us	ician	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 Live Birth	n 2 🗆 Fetal	death 3	Ectopic pregnar Other (specify) _	ncy				ate of deli Ionth	Day Year		
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<u>=</u>	an: The tificate tor, pa	Be Co	25. Was case referred to medical	1			26. F	Place of Dea	ath (Check only	1 Yes	2 - 40	1 \(\text{Yes}	2 2 200		
Χİţ	nysicia lis cer I direc	To B	examiner? 1 \(\sum \) Yes 2 \(\overline{\text{TMO}} \)	Hospital:	atient 2 🗆 B	R/Outpatien	Oti	her	ursing Home 5		ence 6 Lot	her (Speci	Try Asisted Living		
J Of	ing Pł After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of in (Month, E	njury Day, Year)	28b. Time of injury	28c. Inju woi	ĸ?		Describe ho	w injury occur	rred	j		
sior	vttend death ctor: A	Certificate:	2 Accident Investigat 3 Suicide 6 Could not	be co. Blace of the	niury - At hor	ne farm stre	M 1 L et, factory, office	Yes 2		ocation (St	reet and Numi	har or Ru	ral Route Number,		
Division of Vital Records, P.O. Box 687	al or A s after al Dire ed in b		4 Homicide determine	building,	etc. (Specify)	no, iaim, one	or, radiory, ornide			City or Town		ber or ria	a rioute Number,		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Exa	nysician: To the best miner: On the basis of urse Practitioner: To	f examination	and/or investi	gation, in my opin	ion, death o	ccurred at the til	me, date an	nd place, and d	lue to the c	cause(s) and manner stated		
	To with		29b. Signature and title of certifier	fly	m		29c. Licens 12 2	009	74	2	29d. Date fign	ed (Month	n, Day, Year)		
7			30. Name and address of person who	by mp	1411	23a) (Type, P Ma	dun 1	Park	Dru	A C	fer 1	usni	e, me, 2,061		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Regis	trar's Signatu	back	/			,			. ,		
M DHI	MH 17 Rev 06-2		WUY V J CUIT	- CANONIA	1. (

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death October 231, 2011 4c. County of Death 4b. City, Town, or Location of Death Parkville Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth NOV • 20 , 1923 Months 1 □ M 2 🕅 F 87 Massachusetts 10b. County 10c. City, Town or Location Baltimore Parkville 10f. Zip Code 10g. Citizen of What Country? 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □Yes 2 🔼 No Specify Specify: white

1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Jennie Pauline Brown 1:05 PM /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 3115 Hiss Avenue 5. Social Security Number 021–16–8057 9. Birthplace (State or Foreign **Funeral** Director Usual Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits r than "natural", or Items 23e or 28e-f show the Medical Examiner must be notified at MD 1 ☐ Yes 2 No Director 10e. Street and Number 3115 Hiss Avenue Completed by Funeral 11. Marital Status 1 Never Married 2 Married 5-0036 3₺ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medic once. 2121 Own Home Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Be UNK UNK ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dave Brown-son 12225 3rd Street E.Treasure Island, Florida 33706 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral (name).

And Cremation Ser. Belair Nov.3,2011 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Evans Funeral Chapel and Cremation
8800 Harford Road—Parkville, Maryland 4-ME 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Cardiovascu /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Exami the attending physician and Due to (or as a consequence of): the Hospital or Attending Physicien: The law requires that the deeth certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 📉 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 25. Was case referred to medical examiner?

1 XYes 2 ☐ No Be 26. Place of Death (Check onl one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

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Name and address of person who completed cause of death (rem, 23a) (Type, Print) tello, MD

32. Registrar's Signature Trimbl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Claudine Booth Physician/ bot. 7:250N Medical 4a. Facility Name (if not institution, give street and number) #305 4c. County of Death **Examiner** Town, or Location of Death oltimore Social Security Number Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months (Month, Day, 578-22-2064 Director 1 □ M 2 🗹 Carolina Yrs DRC 12 28a-f shov be filed within 72 hours after death with the Maryland ental Hygiene.

ked other than "natural", or items 23a or 28a-f show 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location 10d. Inside City Limits Director Battimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral SMay/WOOD Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 9 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. laci 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Private Elementary/Secondary (0-12) College (1-4 or 5+) Be permit. Page 1 and 2 should be filed
Department of Health and Mental Hy
Important: If item 27 is marked oth
any injury or other transcription. 17. Father's Name (First, Middle, Last) 18. Mgther's Name (Firşt, Middle, Maiden Surname) မ Violet Norman Ynum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) dance Joyce Booth gewood Rd. Battimore 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cremator 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Serfice Licenses 23a. Part 1. Enter the disease of complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying Approximate Interval Between Onset and Death Immediate Cause (Final Phonacasus/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Il-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23h. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the a 2 No g Unknown g Unknown been signed by a Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🐪 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? After this certificate | 1 Yes 2 No Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital မြ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural iniury 5 Pending I Director: A 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) 1940 W. BALTIMORESTREET BALTIMORE, MOZIZZ SANDHU REETINDER MO State Registrar DHMH 17 Rev 06-2011

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HYJICIAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ 8:00 M Rogens Thomas, chase 201 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KHmore Baltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 212-44-0014 Director 1 XM 2 IF 68 Yrs. MD 112 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location notified at Director BAUTIMORE MD 1 XiYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be r Funeral KITMORE Rd 21239 USA Page 1 and 2 should be filed within 72 hours after death viner of Health and Mental Hygiene.

Rant: If item 27 is marked other than "natural", or items inty or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Š 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates Specify: BLACK Completed 3 Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry INSURANCE Elementary/Secondary (0-12) DATA ENTRY Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) HELEN YERBY 2 ALBERT CHASE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20th ST. BALTIMORE, MD. 21213 SISTER Department of Health Important: If item 27 any injury or other tr ATRICIA 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State BALTIMOVE, MD MT Carmel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SUS 21. Signature of Funeral Service Licensee ORK ROAD. BALTIMORE, MD or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dis-shock, or heart failure Approximate Interval Between Immediate Cause (Final Pfaynictery Sudden Candiac disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 C Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perforr death? 1 Yes After this certificate Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. examiner? Other: ဂ္ 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation within 24 hours after death

To the Funeral Director: A
completely filled in by the 1 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State

Registrar
DHMH 17 Rev 06-2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Day 20 11 MARGARET CLARKE OCTOBER 11:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S LANHAM 9885 GREENBELT ROAD Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In yrs, last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 578-28-4688 1 M 2 F Months Days Hours MARCH Day 7 Director 71919 MARYLAND 92 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No PRINCE GEORGE'S LANHAM MD 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a Funeral USA 20706 9885 GREENBELT ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc.
BLACK Completed by 1

▼ Never Married 2 ☐ Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Year or Dates ygiene. her than "natura it, the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE RECEPTIONIST 8th marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ၉ HENRY HERBERT MARGARET CARTER .. Page 1 and 2 should tment of Health and M tant: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6814 WOODSTREAM CIRCLE LANHAM, MARYLAND 20706 PATRICIA A. SMITH/DGT. Important: If iten any injury 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 11/4/2011 LANDOVER, MARYLAND HARMONY CEMETERY J. B. JENKINS FUNERAL HOME, INC. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Litter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) HYPERTENSION Medical Due to (or as a consequence of) Examiner RESPIRATORY ARREST Sequentially list conditions Due to for as a consumence of cause. Enter Underlying Cause (Disease or iinjury Exami physician and s the burial-trans burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 9 Unknown g Unknown P.O. I ģ s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has b lirector, page 2 sl autopsy performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 💢 Natural 5 Pending work? 2 🗆 No Investigation Director: A Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Di

completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examinery On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

X

State Registrar 29b. Signatur

705 DIGITAL DRIVE SUITE G LINTHICUM, MARYLAND 21090 ROBERT WILSON M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

D72180

29d. Date signed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 1, 2011 Kathleen Garrety Carrier Physician/ 12:40 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours May 5 Pay, f933 Pennsylvania 162-26-3977 78 Yrs. **Director** 1 □ M 2 🗶 F Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State the Medical Examiner must be notified at Director N/A 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 1204 S. Potomac Street Funeral 21224 items 23a USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 0 þ 1 Never Married 2 Married Yes Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 No Specify: If Yes, Give Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Greater Baltimore Medical Center Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other I any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Margaret Small မှ Francis Garrety 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State Zin Code) 1204 S. Potomac Street—Baltimore, Mary Land 21224 John Carrier-son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Holy Saviour Cemetery Nov.4,2011 York, Pennsylvania 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 16924 York Road-Monkton, Maryland 21111 fords 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final MONTIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Exami that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician a I for use as the burial-Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Property of the attending physicial function of the attending physicial function. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached a Unknown a Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>۾</u> HYPCRTENSION 2 🗖 No Records, 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2: autopsy performed' 1 Ves 2 No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 - No Hospital: Other: 4 Nursing Home 5 Residence 6 ည 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Mann Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? Natural injury 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 23a) (Type, Print) who completed cause of death (Item

State Registrar 32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

35018

		•	State Registrar			Cert	ificate of D	Death			Reg. No.		
Ī	Physicia		Decedent's Name (First, Middle, Veronica Lucil)	· ·						2, Date of Dea Month OCTOBEL	Day Ye	ear 1	3. Time of Death 2:20 A M
	Medic Examin		4a. Facility Name (if not institution,	give street and number)			4b. City, Town, or			00,000	4c. County of	Death	
أمهد	<i>*</i>		SAINT JUSEPH		ENTE		Tows		Od Has		BALT		
	Funeral Director		5. Social Security Number 213-30-8015 Usual Residence of Decedent	6. Sex 7. Age	93	Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birtl (Month, Day August	(Year)	Count	Baltimore land
	and show	tor	10a. State 10b. County		10c. City, Tox		ation					10	0d. Inside City Limits
	Maryl 28a-f otifie	irec	MD		Balti	more						\perp	1X Yes 2 □ No
	s 23a or	Funeral Director	10e. Street and Number 2828 Roselawn A	Avenue			10f. Zip Code 21214				U.S.A.	t Coun	try?
0	er death or item niner n	by Fur	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Education Armed Forces? ed 1 Yes 24	ver in U.S.	lf	as Decedent of Hi Yes, specify Cuba	n, Mexicar	n, Puerto I		14. Race - Black, V	White, e	etc.
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, Maryland	1 and 2 should by Health and Meritem 27 is marked other traumatic		19a. Informant's Name/Relationshi Debbra C. Huds				,				; City or Town, State ore, Mary		
Baltimore,	e 2 = 5		20a. Method of Disposition 1 → Burial 2 → Cremation 4 → Donation 5 → Other (Sp.		cemet	tery, crem	ition (Name of atory or other place hem Cenet			4,2011	20c. Location - Ci		
Salt	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Lie	censee	1	-					Tuneral C	_	•
	22 2 W O	-	23a. Part 1. Enter the disease, or o	complications that caused	the death. Do						ore, Mary	Lanc	1 21214 Approximate
-	Ph_sician/	8 9	shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line.		2551 (SET)	IYTHM					n	Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a			111111	, , ,					
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7. Ö	that th ned by e detac	oy Ph	Part II. Other significant condition			_		ven in Part	l.	23e. Did to	obacco use contribu	ite to th	ne cause of death?
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Division of Vital Records,	The law re ate has be page 2 sh	Somple	HYPERTENS	10N						24a. Was autop perfo 1 \(\sum \) Yes	osy prid	or to cou	psy findings available mpletion of cause of
<u> </u>	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	ace of Dea					<u></u>
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0	ending eath. or: Afte the fun	ficat	1 X Natural 5 Pending 2 Accident Investig	ation	, rear)	injury	M 1 □	Yes 2] No				
JINISI	al or Att s after de l Direct d in by t	Certificate:	3 ∐ Suicide 6 ∐ Could n 4 ☐ Homicide determin		ry - At home, . (Specify)	farm, stre	et, factory, office			28f. Location (S City or Tow	Street and Number on, State)	r Rural	l Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	(Check 2 Medical Ex	Physician: To the best of r kaminer: On the basis of ex Nurse Practitioner: To the	amination and	or investi	gation, in my opinio	on, death o	ccurred at	the time, date a	and place, and due to	the ca	use(s) and manner stated.
	To the To the comp	~	29b. Signature and title of certifier	1.	1		29c. Licenso		12		29d. Date signed (/	Nonth, l	Day, Year)
			30. Name and address of person w	the completed sauce of	horici		μJ	721	0		10/3/1	20	//
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			Registrar				Cer	tificate of D	eatn	2. Date of	Reg. No	201	1	Time of Death
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	Examin	er	, ,						KVILLE		40.	MONTG		7
	Funeral		SHATY GROV			Age (In yrs. la		If Under 1 Year	If Under 24	Hrs. 8 Date of	Birth	9.1	Birthplace	(State or Foreign
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N. D.			Usual Residence of Dece										10-1-1	nside City Limits
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Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot		21. Signature of Funeral	Service License	9,		22	2. Name and Address	ss of Facility	Metrop	olita	n Fune	rai :	vc.
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			23a. Part 1. Enter the dishock, or heart faile	sease, or comp ure. List only on	lications that ca e cause on eac	used the deat h line.	h. Do not ent	er the mode of dyin	g, such as ca	irdiac or respirator	y arrest,		Int	proximate erval Between set and Death
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-	Medical Examiner		resulting in death)		Due to (o	r as a consequ	uence of :		,					
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376	ficate g phy as the	Je Je					-						_	
89	endin use	an/	IF FEMALE: 23b. Was decedent preg	mani	23c. If yes, outc	ome of pregna		Ectopic pregnan	су		i	23d. Date of	f delivery Da	v Year
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ta	Physician: this certific ral director,	Be	25. Was case referred to examiner? 1 ☐ Yes 2 🗗 No	H-	Hospital:		1	Oth		(Check only one)		0 D Other #	216.0	
₹	Phys this ral dii	은	1 L Yes 2 A No.	<u>'</u>	28a. Date o	npatient 2 of injury	28b. Time of			sing Home 5 28d. Descr		ary occurred	респу)	
n o	ding th. After fune	Certificate:	1 • • • • • • • • • • • • • • • • • • •	Pending Investigation		n, Day, Year)	injury	M 1	k?]Yes 2 □ N	No				
Sio	Atten r deal ctor:	E		Could not be determined	28e. Place			reet, factory, office		28f. Locat	ion (Street a r Town, Sta	and Number o	r Rural Ro	oute Number,
Division	al or s afte				bullain	g, etc. (Specif	у)			City o	r IOWII, Stat			<u></u> -
	lospit 4 hour unera ed fille	Medical	(Chaple 2 1	Modical Evami	ner: On the haci	e of examination	on and/or inve	occured at the time stigation, in my opin	ion death occ	curred at the time. o	date and plac	ce, and due to	the cause	(s) and manner stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 29b. Signature and title	Certifying Nurs	e Practioner: T	o the best of m	ny knowledge,	death occurred at t	ne time, date a	and place, and due	to the cause	e(s) and mann Date signed (M	er as state	u.
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J			30. Name and address of			of death (Iter			- 10 7		,	<u> </u>		
·	8 V		CT Pobles		SHABY		Att.	ENTIST	Hos	PITAL	ROL	KVILL	E, M	18
	Sta	ite	31. Date filed (Month, Da			gistrar's Signa	atura							
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			1101		1									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Novembe Day Physician/ Barbara Nadine Dickinson 2 '110 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Aerundel Severna Park <u>Genesis Eldercare Severna Park</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, May 30, Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Days Indiana 1933 314-32-9571 78 Yrs Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 😾 No Millersville Anne Arundel Maryland 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21108 1047 Rustling Oaks Drive death y 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Catholic Charities Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e Dwayne J. Greggs Mildred L. Hanna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1047 Rustling Oaks Drive Millersville, MD Paul R. Dickinson, Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Metro Crematory Inc. 11/03/11 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor ²Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland Thomas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Dementio disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): ysician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE: Live Birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown 5 Other (specify) signed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 🗌 Yes 2 🗆 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending within 24 hours after death To the Funeral Director; A 1 🗌 Yes 2 🗌 No Investigation 6 Could not be the ☐ Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

Registrar

29b. Signature and title of certifier

Mohit Nesi 1. Date filed (Month, Day, Year)

NOV 0 3 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8601

Veterans

32. Registrar's Signature

29c. License number

Millersville

29d. Date signed (Month, Day, Year)

November 03, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Christos Dardamanis 05:00 AM Medical November 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Siani Baltimore Hospital of Baltimore **Funeral** 8 Date of Birth Birthplace (State or Foreign Country) Hours (Month, Day, Year) Director 216-34-8810 81 1 X M 2 □ F Christos Julv 1. Greece idence of Decede Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. Count death with the Maryland 10c. City, Town or Location Completed by Funeral Director 10d. Inside City Limits 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 149 N. Linwood Avenue 21224 USA - Dardamanis, Maryland 21215-0036 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Specify white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Owner 0 Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Photios Dardamanis Vavoula Bika 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Dardamanis wife 149 N. Linwood Avenue; Baltimore, MD 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Greek Orthodox Cem. 11/3/2011 Woodlawn, MD Signature of Fi 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complic that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Obath shock, or heart failure. List only one Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be execute within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and the burial-tra that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use gontribute to the cause of death? þ cate has been sig ; page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🔁 No Yes 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) 2 **V** No ျ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury 1 Yes 2 No ☐ Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursus Practitionan: To thin best of my investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and ti D63170 341 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Haystal of Baltimm 31. Date filed 32. Registrar's Signature State arka Registrar

=		-	For State	State of Ma	aryland /		ırtment of I <i>tificate of l</i>					20	1	25	022
			Registrar 1. Decedent's Name (First, Middle, I	_ast)		Ceri	incate of t	Jean		2. Date of Dea	Reg. No ath	0./		3. Time o	of Death
Н	Physicia Medic		Edward	F. Doyle,	Jr.					OCTOB	ERDE	31,EO	ear 11	9:52	_t M
-85	Examin		4a. Facility Name (if not institution, g Saint Joseph		enter		4b. City, Town, o		of Death		40	Bal		ore	
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*	Director		216-24-7506 Usual Residence of Decedent	1 X M 2 □ F	82	Yrs.				Oct. 21	, 19	929 N	1ary	land	
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	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral	2519 Putnam F	Road			101. Zip 000e	210	50		rog. Ci	ILIZEIT OT WIT	USA		
	items items		11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S.	13. W	/as Decedent of H Yes, specify Cuba	lispanic O an, Mexica	rigin? (Spe an, Puerto	cify Yes or No- Rican, etc.)		14. Race -	Americ		
36	after al", or	d by	1 ☐ Never Married 2 🔀 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 1 If Yes, Give Year or Dates.	No		☐ Yes 2 🛛 No					Specify:			
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ylan	d be fil Mental arked atic ev	일	Edward Francis	Doyle				An	na P	agano					
Man	should be h and Ment 7 is marke traumatic		19a. Informant's Name/Relationship Marlene Doyle/		19		g Address (Street Putnam							Code)	
re,	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		20a. Method of Disposition	1116		of Dispos	sition (Name of	-		Date	_	ocation - C		own, State	
Baltimore, Maryland 21215-0036	t. Page tment o rtant: If ijury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spo	ecify)		iew	Mem. Gdr	ıs.	11-4-			llsto	n, N	1D.	
Bal	Depar Impor any ir		21. Signature of Furfral Service Lic	ensee		22.	Name and Address 1050 Y	้อฟิร์อี ork	n Fun Rd. T	eral Ho owson,	me, MD.	Inc. 2120	4		
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only		the death. Do	not ente	r the mode of dyir	ng, such a	s cardiac c	r respiratory an	rest,			Approxima Interval Be	tween
yh.	Ph _{sician/} Medical		Immediate Cause (Final disease or condition resulting in death)	a. HYPOXI			TORY	FAIL	URE				-	Onset and	Death
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~	cate be executed physician and s the burial-transit	edical E	resulting in assetty base	d	7										
	ificate ng phy as the	Medi	IF FEMALE:	u											
Box 68	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Birector: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	2 🗌 Fetal dea		Ectopic pregnan Other (specify)	су				23d. Date Mont		ery Day	Year
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la F	ysician: The s certificate director, pag		25. Was case referred to medical examiner?	Į.					eath (Check	1 \(\superstack Yes\)	2 141 14	NOT T	_ 103	2 110	
Ţ	Physic this ceral dire	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 X Inpatie	nt 2 ER/C	Outpatien Time of		4 □ 1		me 5 Resid			Specif	/)	
0 U	nding I tth. : After e fune	cate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investiga	(Month, Day,	Year)	injury	28c. Inju wor M 1	ryan k?]Yes 2[_ 1	28d. Describe h	now inju	iry occurred			
ivisio	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Certificate:	3 Suicide 6 Could no 4 Homicide determin	ot be	ry - At home, t	farm, stre	eet, factory, office			28f. Location (\$ City or Tov			or Rura	l Route Nun	nber,
Ω	Hospita 24 hours Funeral stely fillec	Medical	(Check 2 Medical Ex	thysician: To the best of raminer on the basis of ex	amination and	/or invest	igation, in my opini	on, death	occurred at	the time, date a	and plac	e, and due t	o the ca	use(s) and m	nanner stated.
	Fo the vithin 2 Fo the Somple	ž	only one) 3 Certifying N 29b. Signature and title of certifier	lurse Fractitioner: To the	best of my kn	owledge,	death occurred at 29c. Licens			ace, and due to		se(s) and ma ate signed			
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For State Registrar		State o	† Maryla				Death.		Mental Hyg	iene	201	1 0	
Decedent's Name	e (First, Middle, La	st)	•						2. Date of Deatl		201	3. Tim	e of Death
Nanc	y Kimber	cly Dar	rah						November	2 2 a y	$201^{^{\!Y}\!}\tilde{\mathbf{I}}^{ar}$	4:	17 A™
4a. Facility Name (if	not institution, give	e street and num	ber)		4b. C	ity, Town,	or Locatio	n of Death		4c. C	ounty of Deat	h	
	hrist Hos	spice Ca	re			To	wson				Ba	altimo	re
5. Social Security N			7. Age (In yrs	s. last birthday)	If Ur Mont	nder 1 Year hs Days		er 24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)		hplace (Sta untry)	te or Foreign
214-22-1 Usual Residence	of Decedent	□ M 2 💢 F		Yrs.					March 1			arylar	ıd
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10e. Street and Nur					10f.	Zip Code			1		en of What Co	untry?	
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11. Marital Status		12. Was Dece Armed For 1 Yes	dent Ever in l ces?	U.S. 13.	Was De If Yes, s	cedent of l pecify Cub	Hispanic C ban, Mexic	Origin? (Specan, Puerto	ecify Yes or No- Rican, etc.)	14	 Race - Amer Black, White 		,
1 ∐ Never Marr XX Widowed	ied 2 Married 4 Divorced	1 ☐ Yes If Yes, Give Year or Da	9		1 🗌 Ye	s 2 💢 N	o Speci	ify:		Sį		nite	
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17. Father's Name (i							1		e (First, Middle, M	aiden Su	ırname)		
	Kimberly						שט	prothy	y Bevan				
19a. Informant's Na				. I .	_				al Route Number,			Code)	
Kathari		g/Daught				ole L	ane		nium, MD				
	Sition X Cremation 3 ☐ 5 ☐ Other (Speci		State	. Place of Disp cemetery, cre lantic	matory o	or other pla		Nov 20	. 3,		ation - City or n Burni		
21. Signature of Fat		4ichael		2	2. Name	and Addr	ess of Fac	Home Road	e of Dula Timoni				
	he disease, com rt failure. List only o								or respiratory arres			Approxi	
Immediate Cause (Final	150	lar wa			3000		a +					nd Death
resulting in death)	•	a. Due to (or as a conse	equence of):	- C	HUFF	70	1	7			7=	7.5
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Sequentially list con if any, leading to im- cause. Enter Under Cause (Disease or	nmediate rlying	Due to (or as a conse	equence of):									
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F FEMALE:		23c. If yes, out	come of pred	nancy									
23b. Was decedent in the past 12 r 1 Yes 2	months?	1 Live I 4 Pregr	Birth 2 🗌 Fo	etal death 3		oic pregnar (specify) _	ncy			23	Month	Day	Year
9 Unknown		9 ∐ Unkn	own										
Part II. Other signif	icant conditions of	ontributing to de	eath but not r	esulting in the	underlyii	ng cause g	given in Pa	ırt I.	23e. Did tob	acco use	contribute to	the cause	of death?
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examiner?	No	Hospital:	nnationt of	☐ ER/Outpatie	nt o 🗆	Ot	hor:			N	0.1h a.: /0 -	1 Mil	2006
27. Manner of Death		28a. Date	of injury	28b. Time o		28c. Inju			ome 5 Resider 28d. Describe hov			ITY) V VCS	114
1 🔀 Natural 2 🔲 Accident	5 Pending Investigatio		h, Day, Year)	injury	М	wor		- 1		, ,			
3 Suicide 4 Homicide	6 Could not be determined	28e. Place	of Injury - At	home, farm, st					28f. Location (Str	eet and l	Number or Rur	ral Route No	ımber,

4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 58303 Normber 2, 2011

Charles ST Day Son Mil

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

for State Registrar . Decedent's Nam

Director

Completed by Funeral

To Be

Examine

Completed by Physician/Medical

Certificate: To Be

Medical

Physician/

Medical

Examiner

Funeral Director

32. Registrar's Signature

HAMES MO

Registrar DHMH 17 Rev 06-2011 670i

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death ^{Day} 0, Physician/ Eckman October Robert W. 7:05 2011 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Carrol1 Manchester Longview Nursing Home If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 212-32-9046 Months Hours (Month, Day, Year) Director 08-20-1935 Maryland 76 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Medical Examiner must be notified at Director 1 🗌 Yes 2 ื No Hampstead Carrol1 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4244 Maple Grove Road United States 21074 "natural", or items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Paint Manufacturer Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve Hazel W. Potter Harry W. Eckman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn W. George - niece P.O.Box 788, Hampstead, Maryland 21074 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Meadowridge Mem Park 11-03-2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Funeral Service Licensee Signati Inc, 7250 Wash Blvd, Elkridge, MD 21075 MMP. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Immediate Cause (Final Onset and Death Wladda Cance Physician/ disease or condition resulting in death) 10d-> Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? 1 ☐ Yes 2 ☐ No Yes the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 Yes 2 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27 Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical Lettifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 737573 October 31, 2011 30. Name and address of person who d cause of death (Item 23a) (Type, Print) Batte C/Pr/ 5wth てなろく Z/209 32. Registrar's Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Buddie Joe Edens 2011 3:00 p October 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Sykesville Transitions Health Care Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Funeral 8. Date of Birth g. Birthplace (State or Foreign Months Days Hours Min (Month, Day, Year 1 😾 M 2 🗆 F 214-34-6811 **Director** VA Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Carrol1 New Windsor 1 ☐ Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21776 Funeral 2904 Old Liberty Road 12. Was Decedent Ever in U.S. Armed Forces? 1957

1 1 1 Yes 2 No 1960

If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: white Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical.] once. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) electrical contracting electrical engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nannie Etta Collier Frank Monroe Edens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2904 Old Liberty Rd., New Windsor, MD 21776 Mrs. Norma Edens / spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 DRemoval from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 10-27-11 Sykesville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Warak Harakt P.O.Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown g 🖂 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2100 Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Natural Natural 5 Pending injury 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signafi ure and title 29c. License number 7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAHMUUI

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 405 M Year OGERMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Anne Arundel Annapolis Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) Hours **Director** 281-07-2629 1 M 2 D F 92 Jan. 19, 1919 Ohio ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Anne Arundel Riva 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 3062 Centre Road 21140 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces' þ 1 Never Married 2 X Married X Yes f Yes, Give 2 Nol 941 Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: "natura!", Specify: White 3 Widowed 4 Divorced Completed 1946 Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) Health and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Wholesale Foods Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward H. Fogelman Agnes L. Fritz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 Stacy Fogelman (Son) 3062 Centre Rd., Riva, MD 21140 item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1
Department of Important; If it any injury or o ŏ cemetery, crematory or other place) 2 X Cremation 3 - Removal from State 10/27/11 5 Other (Specify Metropolitan Crematory Donation Alexandria, VA 21. Sig ture of Fineral Service L Traunero Funeral Home 214 S. Monroe St., Tiffin, un OH 44883 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ PNE UMUNIA disease or condition Medical resulting in death) Due to (or as a correquence of). Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No detached 9 Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 Jas autopsy certificate Yes 2 No 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Hospital Other: မှ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work М 1 Tes 2 🗌 No after death Director: / Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 26 2011 2143 and address of person ed cause of death (Item 23a) (Type NNAPOLIS MOZIYO DV NJA WOYYE EXENS F HWY State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - State Amend Item 25 per me,g921,11/01/2011dhb
Registrar

Registrar

Registrar Reg. No. 2 35027 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 18,2011 4:50A OCTOBER Fields Mary Angela Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** BALTIMORE SAINT JOSEPH MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Min April 4, 1920 Maryland Director 215-14-0088 1 M 2 K F 91 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits aţ Director notified 1 Yes 2 XNo MD **Baltimore** Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o with t Funeral 21093 U.S.A. 9 Felton Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black White etc 1 Never Married 2 X Married b Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Meeonee. than Elementary/Secondary (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Cimino Carmelo Curreri Theresa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 123 Galewood Rd., Timonium, MD Josephine Byers-daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Most Holy Redeemer 10/21/11 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. owson, MD 21204 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between RECURRENT GASTROINTESTINAL BLEEDING Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the burial-tran CERTIFICATION APPROVED BY MED and that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death 9 Unknown 9 Unknown ned by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law autopsy page perform Yes 2 X No 1 Yes 2 No Division of Vital the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 X Yes မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No 1 XNatural М within 24 hours after death To the Funeral Director: A Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completely filled in by determined Medical

Registrar DHMH 17 Rev 06-2011

State

To the

29a. Certifier

(Check

only one) 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

BOON POH LIM, M.D.

NOV 0 1 2011

of person who completed cause of death (Item 23a) (Type, Print)
H LIM, M.D. 7601 OSLER DRIVE TOWSON, MD21204

32. Registrar's Signature

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year) 10-18-11

29c. License number

D37254

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15 a M Medical nstitution, give street and number) 4a. Facility Name (if not 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2802 Rosalie Avenue Baltimore Parkville Social Security Numb 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 217-34-4615 Months NOV.111, 1923 Director 1 🗆 M 2 💢 F Mexico 87 or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Parkville MD 1 Yes 2 No 10f. Zip Code 21234 10e Street and Number ō 10g. Citizen of What Country? ian "natural", or items 23a or Medical Examiner must be Funeral 2802 Rosalie Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: white 3 X Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 n and Mental Hygiene. Sales Manager Elementary/Secondary (0-12) College (1-4 or 5+) Retail other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname)
Guadalupe Pedroza 17. Father's Name (First, Middle, Last) 2 Benjamin Pardo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 915 Metfield Road-Towson, Maryland 21286 permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau Christine Wells-daughter 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Lake View Memorial Nov.4,2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ HUDOXIC disease or condition resulting in death) Medical Due to (or as a d Examiner Prevmonio Sequentially list conditions. cause. Enter Underlying
Cause (Disease or injury Due to (or as a son sequence of, and -tran that initiated events resulting in death) Last Due to (or as a consequence of): physician a s the burial-Physician/Medical or Attending Physician: The law requires that the death certificate be 68760 as been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ P.O. Box in the past 12 months? Month Year Pregnant at time of death Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 autopsy page performed? Yes 2 No After this certificate funeral director, pag 2 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 1 No 1 Tes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗆 No neral Director: A ☐ Accident Investigation 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F 29b. Signature and title of certifier 4006426 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO. 2120 Cousurs Brown Mala 31. Date filed (Month, Day, Year) NOV 0 3 2011 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sue Carol Grimes State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day October 31, 2011 Medical Examiner 1620 hrs Sue Carol Grimes 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 1022 Baltimore Road Rockville Montgomery | Months | Days | Hours | Min. | Oct 1, 1947 | Foreign DistrictOf 5. Social Security Number 6. Sex **Funeral** 7. Age (In vrs. last birthday) Director 219-46-6652 1 M 2 XF 64 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland permit. Pages 1 and 2 should be filted within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "oatural", or items 23a or 28a-f she injury or other traumatic evect, the Medical Examiner must be notified at ooce Montgomery Rockville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1022 Baltimore Road 20851 **USA** uneral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married White etc. Yes 2X No Specify: White 3 Widowed If Yes, Give Year 4 Divorced 1 Yes 2 X No specify: ۾ 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Frank Howard Collins Lottie Virginia Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles C. Grimes, Husband 1022 Baltimore Road Rockville, Maryland 20851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 11/02/11 Baltimore, Maryland Metro Crematory Inc. 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee Thomas Gregor 22 Name and Address of Facility Cremation Society Of Maryland, 299 Frederick Road Baltimore, Maryland 21228 the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Hypertensive Atherosclerotic Cardiovascular Disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760, Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, per me, g921 11-16-11 sm X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? ✓ Yes 2 No death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 86 Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural within 24 hours after death.

To the Fueeral Director: Director: 5 | Pending 1 Yes 2 No 2 [Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 [Suicide 6 Could not be determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 1, 2011 use Hame and address of person who completed eduse of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 0/43 (120) (1997) (1997) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#10b, c, e, f, perfh, G921, 11 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ IP PLE RICIA 020 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 682 White Swan Drive Anne Arundel Arnold Social Security Number 9. Birthplace (State or Foreign Country)
Panama 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Days 1 M 2 F Min. Months Hours oct. I, 1934 Director 189-26-4915 Usual Residence of Decede 28a-f shov 10a. State the Medical Examiner must be notified at 10c. City, Town or Location Montgomery 10d. Inside City Limits Director Chevy Chase Maryland Anne Arundel Arnold 1 Yes 2 No 10g. Citizen of What Country? ò 10f. Zip Code 20815 4722 Cumberland Avenue Funeral items 23a 21012 United States 682 White Swan Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. P 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Year or Dates. þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", 3 Widowed 4 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If item 27 is marked other t any injury or other traumatic event, the Graphic Artist Federal Government 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Edward J. Burke Adele Flannigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 682 White Swan Dr., Arnold, Maryland 21012 Ed Gipple / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. [11/02/2011 | Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Marylan 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Inset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last the attending physician thed for use as the buria Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 🗗 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1,—Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cert November 012011 021438 on pleted cause of death (Item 23a) (Type, Print) ANNAPOLIS MD 21401 441) RENSE ENTH W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV O Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 35031 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 30 2011 Physician/ 11:00 PM M Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Jessup 8560 Mission Road 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Days Hours Min 1 M 2 D F 75 Jan. Director 213-32-1097 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10c. City, Town or Location 10a. State 10b. County Director Jessup 1 Y Yes 2 □ No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20794 8560 Mission Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married Yes þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Plumber | Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Mae Smallwood မ Philip Peter Heil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8560 Mission Road, Jessup, Maryland 20794 Miriam E. Heil - Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition remetery, crematory or other place)
Meadowridge Mem. Park 11/04/2011 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.H. 21. Signature Funeral Service 7250 Washington Blvd., Elkridge, MD 21075 M01283 23a. Part 1. Inter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failur. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Heratocellular Medical resulting in death) Due to (or as a consequence of) 7 months Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year in the past 12 months? Month Day 1 Yes 2 g Unknown Yes 2 No ed by the a detached f 23e. Did tobacco use contribute to the cause of death? s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 ☐ Yes 2 🗵 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page 2 1 ☐ Yes 2 ☐ No : After this certifical tuneral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: ျှ 1 🗌 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Matural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier r D0071600 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive, Sik GOZO

Registrar DHMH 17 Rev 7/2009

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32. Registra 's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day HELT 7.45A M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County Hospital Carroll Westminster Social Security Number 8. Date of Birth (Month, Day, Year)
July 17, 1936 Pennsylvania 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 DM 2 X F Months Hours 211-24-8859 75 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 600 Jasontown Road 21158 USA death v 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ♣No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 hours after 1 Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) within 72 I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Computer Tech Supervisor Data Processing 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of Robert Seiders Martha Virginia Bixler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
600 Jasontown Road, Westminster MD 21158 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Marvin W. Helt - Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State Ardent Cremation 11/2/2011 Hanover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, PA 21. Signature of Funeral Service License Mus 2818 E. Baltimore Street, Baltimore, MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 0,51 disease or condition Medical resulting in death) Examiner enkemia eupus Sequentially list conditions Examine If any, leading to miniculate cause. Enter Underlying Cause (Disease or linjury that initiated events Severe Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical that the death certificate be Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 month ō Month Year Pregnant at time of death the 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hospital or Attending Physician: The law requires Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 40 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Mann f Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending Natural work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu ☐ Accident 1 Yes 2 No Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 1) 39502 MD

State Registrar MO

447, EAST MAIN ST

WESTMINSTER MIZIN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DUCMIN

32. Registrar's Sign

SUED

31. Date filed (Month, Day, Year) NOV 0 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:50 M Medical Holliday 201 Lou 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ranklin Rosedale Hospital Square Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country)
 Virginia 1 □ M 2**X** F Months Hours (Month, Day, Yea 7/8/1922 Director 230-40-5282 Usual Residence of Decedent 10a State the Maryland 10b County notified at Director 10c. City, Town or Location 10d. Inside City Limits 28a-f 1 Yes 2 No Maryland Baltimore Middle River ō 10e. Street and Number "natural", or items 23a o 10f. Zip Code 10g. Citizen of What Country? Funeral 92 Torque Way 21220 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces þ 1 Never Married 2 Married Black, White, etc. Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 XVidowed 4 Divorced Specify: Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Seamstress Sewing Be Department of Health and Mental H. Important: If item 27 is marked oth any injury or other traumation once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ John Thomas Sally Nichols 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lou Jean Wager (Daughter) 1124 Rosanda Court Middle River, Maryland 21220 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 X Other (Specify Entombment Holly Hill Mem. Gard. Middle River, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Confficie WITTS disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). to (or as a consequ resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Live Birth 2 Live and Company Pregnant at time of death Unknown Day Year Part II to Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, TE MENTZ FAILURE Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 屎 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▶ No 24a. Was an autopsy performed? Yes 2 2 N Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital မှ Other: 1 Ninpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: ☐ Acciden 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) PHISHAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 02^{Day} Nov. Arnild Hill 201^{Year} Bradlev 6:00 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death <u>Whitewood</u> <u>Trail</u> Crownsville Anne Arundel Year If Under 24 Hrs **Funeral** 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Year) 215-52-8622 Hours **Director** 60 1 😿 M 2 🗆 F Usual Residence of Decedent June 17, 1951|Tennessee show 10a. State be filed within 72 hours after death with the Maryland notified at 10b. Count 10c. City, Town or Location Director 10d. Inside City Limits 28a-f 1 Yes 2 No Maryland Anne Arundel Crownsville 10e. Street and Number 10f. Zip Code permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be rany injury or other traumatic event, the Medical Examiner must be range. 10g. Citizen of What Country? Completed by Funeral 856 Whitewood Trail 21032 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify. 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ike Winslow Hill Lillie Etta McKinney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bill Hill / Son 855 Whitewood Trail, Crownsville, MD 21032 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. 11/03/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a conse wence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a attending physician and for use as the burial-tran Due to (or as a conse resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year signed by the ar 2 No Yes g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed been signal 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has funeral director, page 2 performe 2 🗆 No Yes 2 XNo 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident injury 5 Pending work? Investigation 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 24 hours Funeral completely within 2 To the I

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State

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Gl

ROM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MID

32. Registr

12

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

0052023

Defense Highway

29d. Date signed (Month, Day, Year)

Swife 200 Annapolis

NOV. 02. 2011

29c, License number

3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death ent's Name (First, Middle, Last) 3. Time of Death November Physician/ 0800 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HORE HOSP 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral 313 Months Hours Director shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Funeral Director timore 1 Yes 2 ☐ No 10f, Zip Code 10e Street and Number 10g. Citizen of What Country? USA 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11, Marital Status Armer Forces? 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be Middle, La 18. Mother's Name (First Middle) ٩ 7080N ute Number, City or Town, State, Zip Code) tolland 20b. Place of Disposition (Name of cemetery, crematory or effect) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) . Signature of Funetal Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Troke disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician; The law requires that the death certificate be Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Holland 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 5 Pending Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier 29d. Date signed (Month, Day, Year) \01S~ 10 hamed 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 21. Signature of Fu	5 Other (S		Du.	laney	y Va T 22	alley	7 Men	noria	1 Ga	rdens		imoni				
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1 (Check 2 optrone) 3	Medical E	Physician: To the be xaminer: On the basis Nurse Practitioner:	of examinati	on and/or	investig	gation, in	my opinic	n, death o	ccurred a	t the time, date	and p	lace, and du	ie to the	e cause(s) and	manner:	stated.
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51		30. Name and addr	ess of person v	who completed cause	of death (Ite	m 23a) (T	ype, Pr	t. S	Suit	e 41	,05	Ball	ત્તર	سعدو	1	10 21	ام د	+
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OBERDAY 25 12 40 AM 2011 Samuel Leonard Hughes, Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE WASHINGTON MEDICAL enter GLEN SHUE 9. Birthplace (State or Foreign Country) Maryland If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 83 Yrs. If Under 1 Year **Funeral** Nov. 28 1927 1 🕅 M 2 🗆 F 220-22-7156 Director Usual Residence of Decedent 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland | Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21108 8221 Jumpers Hole Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑Yes 2 □ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Norine Sullivan Samuel Leonard Hughes, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8221Jumpers Hole Road, Millersville, Maryland 21108 Dorothy E. Hughes - Wife 20a. Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Ardent Cremation, Inc. 10-27-11 Hanover, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. Signature of Funeral Service Licenses michael 6009Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BRO disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IE EEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live Birth 2 Fetal death 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Year Day Pregnant at time of death 2 No ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and address of person who ette Craka 32. Registrar's S State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Ĥ	Frances Harr	ris(wife)				ice]	lot L	ane,	Colu	umbia	, M	D 21044
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Be C	25. Was case referred to medical examiner?	7			26. F	Place of De	eath (Check	1 \(\sum \) Yes only one)	2 Danie	0 1 -	Yes 2	LI NO
은	1 ☐ Yes 2 No 27. Manger of eath	Hospital: 1 Inpa		ER/Outpatien	t 3 LI DOA			ne 5 X Resid			Specify)	
Certificate:	1 Natural 5 Pendin 2 Accident Investig	ng (Month, D	lay, Year)	injury	28c. Inju woi M 1 [_	8d. Describe h	now injury	y occurred		
ij	3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Ir	njury - At ho	me, farm, stre	et, factory, office		2	8f. Location (\$			r Rural R	Coute Number,
Φ												
	OO- Condition .			and/or invest	igation, in my opin	ion, death	occurred at t	he time, date a	and place,	, and due to	the caus	e(s) and manner stated
		xaminer: On the basis of		ny knowledae.	death occurred at	the time, t			ine cause	e(s) and mani		
	(Check 2 Medical E	xaminer: On the basis of Nurse Practitioner: To t		ny knowledge,	29c. Licens	se number		le, and due to t	29d. Dat	te signed (N		
	(Check 2 Medical E only one) 3 Certifying 29b. Signature and title of certifier	examiner: On the basis of Nurse Practitioner: To the Samuelle Control of the S	the best of m	4)	29c. Licens			e, and due to	29d. Dat			
Medical Ce	(Check 2 Medical E only one) 3 Certifying 29b. Signature and title of certifier	xaminer: On the basis of Nurse Practitioner: To the Nurse Practitioner: To the Nurse Practitioner: To the Nurse Practitioner: To the Nurse Practition Practical Practi	death (Item	23a) (Type, P	29c. Licens	850	g		Noju	te signed (M	3	iy, Year) 2011
	(Check 2 Medical E only one) 3 Certifying 29b. Signature and title of certifier	warminer: On the basis of Nurse Practitioner: To the Nurse Practitioner: To the Nurse Practitioner: To the Nurse Practitioner: To the Nurse Practical Practi	death (Item	23a) (Type, P	29c. Licens	850	g		Noju	te signed (M	3	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryland			1ental Hygier	ie	05000
			State Registrar		Certificat	e of Death	Reg.	No. 2	35039
	Physicia	n/	1. Decedent's Name (First, Middle, Last)	Ha	11:5		2. Date of Death	Day Year	3. Time of Death
	Medic	al	4a. Facility Name (if not institution, give st	treet and number)	1 Ab City	Town, or Location of Death		4c. County of Death	7. 0/1
	Examin	er	1400 E. mad	· CITE	103 45.011	3alt m	ri	MA	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday) If Under	r 1 Year If Under 24 Hrs. Days Hours Min.	8. Date of Birth Month, Day, Yea	r) Cou	hplace (State or Foreign intry)
	Director		110 01- 7300	M 2 AF 82	Yrs.	Days Flours Will.	July 10,	1929 1	naryland
	how at	٦	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Limits
	arylar ta-fsl	ectc	md.	NA P	re Itin	mare)			1 No 2 No
	or 28	ρ	10e. Street and Number		10f. Zi	o Code	10g.	Citizen of What Co	untry?
	s 23a nust b	Funeral Director	1400 E. made	Son St. #	403	21205		<u> USA</u>	
	death ritem ner m	Fur	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
36	after al", or xami	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1 🗆 Yes	2 XNo Specify:		Specify: B	1ACK
21215-0036	hours natur lical B	Completed	15. Decedent's Edu	ucation	16a. Decedent's Usu	al Occupation ork done during most of work	ing 16b	. Kind of Business I	
2	nin 72 re. han " e Mec	шо	(Specify only highest grad	College (1-4 or 5+)	life. DO NOT us		1004	Univer	to plans
7	d with Hygien ther th	Be C	17. Father's Name (First, Middle, Last)	MITT	Janel	18 Mother's Nam	e (First, Middle, Maio		
Maryland	Id be filed within 72 hours after death with the Maryland Mental Hygiene. rarked other than "natural", or items 23a or 28a-f sho artic event, the Medical Examiner must be notified at	ToE	(?)	FR Ste	rling	Se	lina	Chir	7
ary.	should and Me is mar raumati		19a. Informant's Name/Relationship (Typ	pe, Print)		s (Street and Number or Run		or Town, State, Zip	Code)
	and 2 st Health a tem 27 is		Helen F. Wrigh	if - mend	1804 Ra	mblewood			nd. 21239
Baltimore,	e 1 and of Heal If item 3		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F		ce of Disposition (Na metery, crematory or	other place)	Date 20d	. Location - City or	
Ē	Page 1 tment of tant: If it tant: or o		4 Donation 5 Other (Specify)	me	to Cr	emalory 11-	5-//		Tille, MD.
Baj	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Sign the of Funeral Service License	11,10110		nd Address of Ficility 3	Mace F.	S. Bali	10, mg, 21229
			23a. Fart 1 Enter the disease, or compli	ications that caused the death.		7.7		3. /sec.	Approximate
133	Physician/		: shock, or heart failure. List only one Immediate Cause (Final	e cause on each line.	mulan	1.			Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a consequen	nce of):	my			
	Examiner	_	Sequentially list conditions,	. Oren	monia				
	p #	nine	if any leading to immediate cause. Enter Underlying	Due to or a a consequer	nce of):				
	ecuter and trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):				
0	ate be executed bhysician and the burial-transit	dical		1					
3760	ficate g phys	Nedi		1.					
89	eath certifica attending p	an/N	23b. Was decedent pregnant	3c. If yes, outcome of pregnand		pregnancy		23d. Date of de	
Division of Vital Records, P.O. Box 687	death he att	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of deag ☐ Unknown				Month	Day Year
0	requires that the de been signed by the should be detached	Ph	Part II. Other significant conditions cor	ntributing to death but not resul	ting in the underlying	cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
S,	signe d be c	d by					1 ☐ Yes	2 No 3 □ P	robably 4 🗌 Unknown
ord	been	lete					24a. Was an	24b. Were au	rtopsy findings available completion of cause of
ec	he law te has age 2	ошо					autopsy performe 1 \sum Yes 2	d? death?	s 2 No
E H	an: Tl rtifical tor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death (Chec		3 110	
⋛	hysic his ce I direc	10	1 🗆 Yes 2 🗷 No	lospital: 1 Inpatient 2 E			ome 5 Residenc	"	cify)
o c	ling P	ate:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	injury	28c, Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred	
sior	death ctor: /	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hom	M ne, farm, street, facto		28f. Location (Stree	t and Number or Ru	ıral Route Number,
Ξ̈́	al or A safter I Direct		4 Homicide determined	building, etc. (Specify)			City or Town, S	tate)	
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Charle O Madical Evamin	ician: To the best of my knowled ner: On the basis of examination a	and/or investigation in	my opinion, death occurred :	at the time date and r	lace, and due to the	cause(s) and manner stated.
	the H hin 24 the F	Me	only one) 3 Certifying Nurse	e Practioney: To the best of my h	knowledge, death occ	urred at the time, date and pla	ice, and due to the ca	use(s) and manner as	s stated.
	vit Co		29b. Signature and title of certifier	V VX	0	DAD 1. 44C	V 290	Date signed (Mont	/ / 1
	}		30. Name and address of person who co	ompleted sales of death (Item 2	23a) (Type, Print)	0000113		-1///	
			Iranee Kechi	x 5889 Re	stestu	n Rel Sur	419 ba	Hynrice 1	MD 21215
	Sta		31. Date filed (Month, Day, Year)	32. Fugistrar's Signatu	A Low	,		•	
	Registr	ar	NOV 0 3 20	III Dueva A	J. Sparke				

11-08134 R

Please Type or Print în Black Indelible Ink. Ensure All Copies Are Legible.

onnie Jackson	1- For State Certificate of Death Reg No. 2011 3504									1 35041			
Physicia		Registrar 1. Decedent's Name (First, Middl	e,Last)			_				2. Date of De Month	eath Day	Year	3. Time of Death 0830 hrs
ledical Examin		Ronnie Jacks				1			-tit D	October	30, 20	011 c. County of Death	
		4a. Facility Name (if not institution Johns Hopkins Hospit		mber)		4	b. City, Tov Baltimo	re				N/A	
Funeral Director	- 1	5. Social Security Number unk	6. Sex		rs. last birth 45	day) Yrs.	If Under Months		f Under 2 Hours	4Hrs. 8. Date of I		Foreig	thplace (State or gn untry) MD
" ——	ŀ	Usual Residence of Decedent			- · · · · · · · · · · · · · · · · · · ·								10d. Inside City Limits
w any		10a, State 10b. County		10c.	City, Town o								1 X Yes 2 No
Aaryland 28a-f show 1 at once	힑	MD N/A				ват	timo:				10a. Cit	tizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once	Director	945 Forrest	C+				212					U.S.A.	
with th		11. Marital Status	12. Was Dec		in U.S.	13. Was	Decedent	of Hispan	ic Origin	? (Specify Yes or I	No-		ican Indian, Black,
death or item	Funeral	1X Never Married 2 M	1 Yes	2 X	No	If Ye		-		uerto Rican, etc.)			
ral", o	ᆰ		orced If Yes, Give Yea or Dates:		d) 160 F		Yes 23X			d of work done	116b	Specify: B1 Kind of Business/	
"natu	eted	 Decedent's Education (Spe Elementary/Secondary (0-12) 	College (1				st of worki				1	Tallo of Basilloss	
5-0036 led within 72 hours tygiene tygiene typer than "natur the Medical Exam	Comple	11th Grade		,	P	res	ser					Dry Cl	eaners
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical		17. Father's Name (First, Middle								Name (First, Middle	e, Maider	n Surname)	
d be fi	8	Fred Jackson 19a, Informant's Name/Relations			19b	Mailing	Address			McNair or Rural Route N	umber, (City or Town, State	e, Zip Code)
mb 2121 and 2 should be fi fealth and Mental I tem 27 is marked traumatic event,	유	Rita Jackson)						., Balt			
ore, MC s 1 and 2 sl of Health ar If item 27 her trauma	1	20a. Method of Disposition	• C B		20b. Place o		tion (Name er place)	of cemete	ery,	Date	20c.	. Location - City or	Town, State
Pages ent of int: If	- 1	1 Burial 2 K Cremation 4 Donation 5 Other S		om State	on-si	•		ator	У	11/02/1	1 Ba	altimor	e, MD
The first with the first of the first widdle, Last) The first widdle, Walden Surname) The first widdle, Last) The first widdle, Last wide wide wide wide wide wide wide wide											e PA		
	(A)											Approximate Interval	
Physician Wedical		failure. List only one cause	on each line.					, ,,					Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			"			_				
	Ļ	Sequentially list conditions,	b Due to (or as a	0000000000	aco of):								-
	ije Pi	if any, leading to immediate Enter Underlying Cause (Disease or injury that initiated	č										
scuted and transit	Examiner	events resulting in death) Last	Due to (or as a	,	·								
), be executed sician and urial - transi	dical	UNPENDED	X AMENDED	23 pt	.II pe	r me	g922	2 12-	-28–1	1 vt			
tox 68760 eath certificate be attending physi for use as the bu	≝i	IF FEMALE: 23b. Was decedent pregnant in t	23c. If yes,		pregnancy		al death	3 🗍	Ectopic p	regnancy	2	3d. Date of deliver Month	ry Day Year
Box 6876C e death certificate the attending phys ed for use as the b	siciar	past 12 months?	4 Pregr	nant at time	of death 5		ner (Specil				1		
Bo he death the ath	2	Part II. Other significant condi	known 9 Unkn			in the	adarkion o	auga giya	n in Bod	1 23e Di	d tobacc	o use contribute to	the cause of death?
of Vital Records, P.O. ag Physician: The law requires that the three this certificate has been signed by neral director, page 2 should be detach	Ą		Dehydrati					ause give	IIIIIFait				obably 4 Unknown
rds, l										24a. W			utopsy findings available completion of cause of
cor law r e has b e 2 sh	Completed	Atheroscler	otic card	TOVAS	culai	DISC	ase			pe	topsy rformed s 2	? death?	
Vital Rec	S	25. Was case referred to medical	al Language of the second				26	S.Place of	Death (C	heck only one)	5 2		
Vita ysicia ysicia direct	e e	examiner? 1 Yes 2 No		Inpatient	2 🗸 ER/0	utpatient	3 🔲 DC	A Oth	ner ₄ !	Nursing Home 5	Resid	dence 6 Othe	ər:
J Of Jing Ph		27. Manner of Death		of Injury h, Day,Year)	28b.	Time of I	· ·	Sc. Injury a			oe how ir	njury occurred	
(Month, Day, Year) 1 V Natural 5 Pending Investigation Investigation 2 Accident 2 Accid										ural Route Number, City			
Division pital or Attendia ours after death. teral Director: △	Certific		ald not be ermined (Specify)		- At nome, ta	ırm, stree	et, ractory, i	onice build	aling, etc.		n, State)		arar roug rambor, org
Division of Vital Records, P.O. Box 68760 To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying F	Physician: To the be aminer:On the basis	st of my kno	owledge, dea	ath occur	red at the t	ime, date	and place	e, and due to the c irred at the time, d	ause(s) a	and manner as sta place, and due to t	ated. he cause(s)
To t	Medical	29b. Signature and little of certifi	and manner:	stated.	7.7			License n				d. Date signed (M	
		9/10h 3/1	1/2 3/00 1	120	8			O.C.M.	E.		00	ctober 31, 201	11
_		30. Name and address of perso				000.14	/ Dali:	- C1	of De	Himara MD C	1222		
		Victor Weedn MD JD		edical Ex		900 W	. Baitim	ore Stre	ei, ba	Itimore, MD 2			
St Regist	ate rar	31. Date filed (Month) Pay Year	3 2011	men	1	ba	Kel						
DHMH 17 Rev 1/20	001		OCME		ÓR	IGINA							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 230 AM Physician/ 2011 Esther Krul Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Square Baltimore Roseda FRANKLIN HOSPITal 5. Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday) 6. Sex Funeral Days Min Hours April 10ay 273 ar) 1924 1 M 2 X F 219-10-7042 Pennsylvania Director Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Baltimore Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 Walther Blvd 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 XNo Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home improvment Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Matilda Wedeman William F. Timme 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 134 Holly Circle Essex, Maryland Robert Krul / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

DulaneyValleyMem.Gdns 11/4/2011 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland 4 Donation 5 Other (Specify) Signature of Europai Service List 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or con Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a d be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ facture 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed? 1 ☐ Yes 2 ☐ No this certificate Yes 2 No 25. Was case referred to medical examiner?

1 \sum Yes 2 \sum No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28b. Time of Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. mpleted 3 🗌 the only one) within To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 11-1-2011 D00554 9000 Balto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Qay, Year) NOV 0 3 2011

32. Registrar's Signature

md 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 31, Physician/ 5:30 P M 2011 King Alice Love Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Cockeysville 10706 Westcastle Place, APt. T-4 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 \(\hat{D}\) M 2 \(\frac{X}{2}\) F 6 - 27 - 1 9 2 2 Marviand 89 220-22-8631 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f sho must be notified at Director 1 🗌 Yes 2 🎇 No Cockeysville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 21030 10706 Westcastle Place, Apt. T-4 items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?
1 Yes 2 No Black White, etc. 6 1 Never Married 2 Married ģ permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) မ Love Schmidt Raymond Emma W. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21030 19a. Informant's Name/Relationship (Type, Print) 10706 Westcastle Place, Apt. T-4 Cockeysville, MD John W. King Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Service Corp. 11-3-2011 4 ☐ Donation 5 ☐ Other (Specify) Towson Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 22. Name and Address of Facility 1050 York Road Sin an e of Funer Service U. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MINUTES disease or condition Medical resulting in death) Due to or as a consequence of Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Physician/Medical Examine Die to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 nding p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to edical Medical Certificate: To Be examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifie 153095 30. Name and address of person who completed cause cf death (Item 23a) (Type, Print) (TEXAS STATION COURT #210 TIMONILES NO Registrar's Signa State 3 2011 NOV 0 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ^{Day} 31 2011 HARRIET OCTOBER KOPPELMAN 04:15A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Months Davs Hours (Month, Day, Year) Director 213-52-9347 1 🗆 M 2 🗓 F Usual Residence of Decede 02/18/1954 NY 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10h Count must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No BALTIMORE BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral 32 STONE PINE COURT 21208 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian Armed Forces? Black, White, etc ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give 3 Divorced Specify: Completed Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the 5+PHYSICIAN MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ HOWARD JOSEPH COHEN BERNICE SCHATZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK KOPPELMAN/HUSBAND STONE PINE COURT, BALTIMORE, MD 21208 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Date permit. Page 1
Department of I
Important: If its
any injury or of 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify, MOSES MONTEFIORE 11/02/2011 BALTIMORE, MD . Signa 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complicate shock, or heart failure. List only on care ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Immediate Cause (Final Onset and Death Ph sician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 month 1 Yes 2 No Ectopic pregnancy Pregnant at time of death g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 24 hours after death.

Funeral Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2XNo မြ Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 5 Pending injury Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Dentifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatu and title of cert D0071287 Name and address of person who completed cause of death (Item 23a) (Type, Print)
WWA Shaheey, 6701 N. Charles St. Suite 4105, Baltin 21204 32. Registrar's S State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ october Esther Kellhofer 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🗓 F 322-28-2748 Months Hours Oct. 15 Country) 79 **Director** Usual Residence of Decedent or 28a-f show 10a State 10b. County death with the Maryland any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Millersville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 8310 West Side Drive 21108 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 1 Never Married 2 Married Black, White, etc. þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Maryland 21215-0036 1 Yes If Yes, Give 2 💢 No 1 ☐ Yes 2 ☒ No Specify: Specify Completed 3 - Widowed 4 X Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Postal Service U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Walter Wemple Lucy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy McKinney (daughter) 8310 West Side Drive, Millersville, MD 21108 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 03 Nov. 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 2011 Baltimore, Maryland Signature of uner 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only of eight a cardiac or respiratory arrest, and the cardiac cardiac or respiratory arrest, shock, or heart failure. 23a. Part 1 Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy perform 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ဂ္ 1 Tyes 2 **2** No Other Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending Accident 1 Tes 2 No Investigation 24 hours after deat Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 3 2 2011 who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

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Kellhofer,

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 201T 11:00 A M ROSE LEWINTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE TIMONIUM LORIEN MAYS CHAPEL NURSING HOME 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 □ M 2 X Hours Min. Months Days 0370471917 Director 94 131-01-8928 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State Examiner must be notified at Director 1 ☐ Yes 2 🔀 No BALTIMORE MD BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or Funeral 21208 USA 16 OLD COURT ROAD Page 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene. Iant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. Yes 2 XNo Specify: WHITE 3 XWidowed 4 □ Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME 4 HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ BRATTER NEBELKOPF CLARA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12236 ROUNDWOOD ROAD, #205, LUTHERVILLE, MD 21093 DAVID LEWINTER/SON 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State OHEB SHALOM MEM PK 11/02/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the diseas. — complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate nterval Between Onset and Death Immediate Cause (Final hysician/ Medical resulting in death) Due to (or as a consequence of): Examiner 120 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami the Hospital or Attending Physician: The law requires that the death Certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 No Certificate: To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 🗌 No Accident Sulcide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

Division of Vital Records, P.O. Box 68760 the Funeral Director: After thi npleted filled in by the funeral 24 hours

Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) RNI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Roger S. Mills 2011 2011 9:30 A M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kent Chester River Manor Chestertown Social Security Number If Under 24 Hrs Hours Min. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Country) Delaware Month, Day, Year 45 221-28-8270 Aug 66 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Marydel 1 XYes 2 No Queen Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21649 USA 715 Everett Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 🔀 Yes 2 🗌 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **2+** Elementary/Seconday (0-12) Private Exterminator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jerry Mills Nettie Ware 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1122 Dudley Corners Road, Millington MD 21651 Bonnie Schelts - daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 🛭 Cremation 3 ☐ Removal from State Ardent Cremation 11/3/2011 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services 2818 E. Baltimore Street, Baltimore MD

Baltimore, permit. Page 1 Department of Important: If it Physician Medical Examiner

attending physician and

signed by

After this

within 24 hours after deat To the Funeral Director:

Completed by Physician/Medical

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Certificate:

Medical

29a. Certifier

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

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10a. State

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other traumatic event, the Medical Examiner must be notified at

be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition resulting in death)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Respiratory s a consequence of): Due to (or as a consequence of)

Approximate Interval Between Onset and Death Human chstraterifficuoray Acresse with Oz Dependency

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? g Unknown

Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28b. Time of

23d Date of delivery 3 Ectopic pregnancy 5 Other (specify)

23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown

Month

BitAteral Pulsionary Active succken

24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv performed?

1 Yes 2 No death? Vec 2 No

CHURIT PAIN SYN drown with Opiaite Appendence 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death

Other: 4 Nursing Home 5 Residence 6

	Tes Z	140	2 🗆 140
k onl	y one)		
ome	5 Residence	6 Other (Specify)	
28d.	Describe how ini	ury occurred	

27. Manner of Death Natural 5 Pending Accident Investigation 6 Could not be Suicide determined

28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

223 1/186 Street, CKertestown, ned. 21920 TR 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35047 State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edward Joseph Martin, Sr. 4:30 PM M 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center for Hospice Baltimore Towson 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Hours Director 214-26-5285 1 ▼ M 2 □ F 80 11/25/1930 Maryland 28a-f show 10b. County 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Baltimore Maryland Dundalk 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral Belmont Avenue 7416 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. X Yes 2 No 1948 þ 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No Specify: Hygiene. other than "natural", Specify: 3 Widowed 4 Divorced Completed 1952 White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Painter Automotive Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomas L. Martin Ella Winkler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmeline Martin (Wife) 7416 Belmont Avenue Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl Date 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 11/5/2011 Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complicity insit but cause 1 the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of faciline. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer Montry disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Day Month Year 1 Yes 2 9 Unknown q Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, f. 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 ☐ Yes 2 🗷 No 4 Nursing Home 5 Residence 6 2 Other (Specify, မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in any article of the cause of Medical 29a. Certifier Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature ind title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CH ANUN M() 6101 32. Registrats Signature State NOV 0 3 2011 Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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**	Medi	cal	LARRY 4a. Facility Name (if not institution,	I	MCDOV	VELL				OCTOB	ER 26	2011		2:35	P M
man (Exami	ner	PRINCE GEORGE				4b. City, Town, or CHEVE		of Death			County of Deat		GE 'S	
	Funeral		5. Social Security Number 578-92-9027		(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Day		g. Bir Co	thplace	e (State or	Foreign
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	yland -f sho ed at	ctor	10a. State 10b. County		10c. City, Tow									Inside City	·
	he Mai or 28a o notifi	Dire	MD PRINCE 10e. Street and Number	GEORGE'S	GLEN	IARD1	EN 10f. Zip Code				10a Citiza	en of What Co		1 X Yes	2 LJ No
	s 23a ust be	Funeral Director	8646 FULTON ST	REET			20706	·			USA		on try .		
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 🛣 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? d 1 Yes 2 If Yes, Give Year or Dates.			/as Decedent of Hi Yes, specify Cubar		jin? (Spec , Puerto R	ify Yes or No- ican, etc.)		4. Race - Ame Black, White pecify: BLA	e, etc.	ndian,	-
21215-0036	vithin 72 hou iene. ir than "nati the Medica	Completed	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education grade completed) College (1-4 or 5 3 YRS	+)	(Give ki life. DC	ent's Usual Occupa ind of work done d NOT use retired)	ation luring most	of working	g		d of Business	/Indust	ry	
Maryland 2	d be filed v dental Hyg irked othe tic event,	To Be	17. Father's Name (First, Middle, La. IRZEAL MCDOWELI	st)						(First, Middle,	Maiden Su	ırname)			
Aary	should and I		19a. Informant's Name/Relationship		198	o. Mailing	g Address (Street a	nd Number	r or Rural	Route Number	r, City or To	own, State, Zij	o Code	2074	7
	and 2 s Health tem 27		MINDEY MCDOWELL 20a. Method of Disposition	/WIFE	20h Place o	f Disnos	ADDISON ition (Name of	- :		H DIST		HEIGHT ation - City or			AND
Baltimore,	. Page tment o tant: If jury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Sp 21. Signature of Funeral Service Lice	ecify)	cemete	NY (atory`or other place CEMETERY	1	1/1/		LAN	DOVER,	MAR	YLANI	
Ba	permit Depar Impor any in	-	21. Signature of Funeral Service Lic	ensee			Name and Addres 74 LANDO		400						
	Physician/ Medical Examiner	Examiner	23a. Part 1 Enter the disease, or control shock of heart influre. List only immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a. Due to () as a	consequence consequence	of):							Inte	proximate erval Betw set and De	eath
3760 N.R.	cate be executed physician and s the burial-transit	ledical Exa	that initiated events resulting in death) Last	С.	consequence (of):							,		97
Box 68	requires that the death certifica been signed by the attending pl should be detached for use as t	≥	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at g Unknown	2 🗌 Fetal death		Ectopic pregnancy Other (specify)	/			23	3d. Date of de Month	livery Day	, Ye	ear .
ds, P.O.	quires that the consideration of the constant of the details of the details of the details of the constant of	þ	Part II. Other significant conditions	s contributing to death bu	t not resulting i	in the un	derlying cause give	en in Part I.				contribute to			_
Division of Vital Records,	The law ate has page 2	Completed								24a. Was a autop perfor	rmed?	24b. Were au prior to death? 1 \square Yes	comple	etion of ca	/ailable use of
/ital	/sician: The s certificate director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 🗆 ER/Ou	tnationt	Othe	ce of Death				7 041 (6	16.1		
on of	To the Hospital or Attending Physician: In the Funeral Director. After this certific completely filled in by the funeral director,		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	/ 28b. T	Time of njury	28c. Injury work?	at	28	e 5 Resid			ту) _		
Divisi	i Hospital or Attending 24 hours after death. Funeral Director: After etely filled in by the funer		3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	ed 28e. Place of Injur building, etc.	(Specify)					Bf. Location (S City or Tow	n, State)			ite Numbe	ır,
:	e Hosp 24 hor e Fune eletely fi	Medical	(Check 2 Medical Exa	hysician: To the best of n miner: On the basis of ex urse Practitioner: To the	amination and/o	r investig	ation, in my opinior	n, death occ	curred at the	ne time, date ar	nd place, a	nd due to the o	cause(s		
	To the comple		29b. Signature and title of certifier	tamelo n	D		29c. License	number	82	2/3	29d. Date	signed (Month	n, Day,	Year)	
_	10		29b. Signature and title of certifier 30. Name and address of person wh FARHAD JAM 31. Date filed (Month, Day, Year)	o completed cause of de	ath (Item 23a) (Type, Pri	na polis	PJ	61	en D	ale	MD	20	76	9
	Stat Registra	e	31. Date filed (Month, Day, Year) NOV 03 2	32 Registrar	's Signatur	Ba	(C)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death P Day Physician/ Month 2 ma 0 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** DEC. 12 242-34-0132 Months NORTH CAROLINA 1928 Director 1 M 2 X F 82 Yrs 28a-f show 10b. County 10d. Inside City Limits 10a. State the Maryland 10c. City. Town or Location notified at Director 1X Yes 2 No PRINCE GEORGE'S BOWIE MD 10f. Zip Code ò 10e Street and Number 10g. Citizen of What Country? ms 23a or must be n Funeral USA 20716 3906 NORWAY LANE items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Examiner 0 1 Yes 2 No If Yes, Give Year or Dates. by 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) Elementary/Secondary (0-12) the PRIVITE SCHOOL TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked o မ RIDLEY HARRIET PEARSON SPAULDING 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3906 NORWAY LANE BOWIE, MARYLAND 20716 ALLEN MCPHERSON/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) RIVERDALE, MARYLAND 11/3/2011 RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME, INC. Signature f Fun La Strvice Licer 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Acute Physician/ Myocandial disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events Exami resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 the attending phase as the IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a Yes 2X No 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an certificate has the autopsy performed Yes 2 or Attending Physician: The 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tes 2 🛮 No ္ဝ 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director, After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M 13318 10/31

Registrar DHMH 17 Rev 06-2011

State

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J, Lee

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ST.NW

112VING

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35050 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 01, Chester Moore 2011 5:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1705 Deep Run Road, Whiteford Harford Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday Days Hours 216-50-2488 **Director** 1 🛛 M 2 🗆 F 62 March 21, 1949 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f st notified Maryland Harford Whiteford 1 🗌 Yes 2 💢 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 1705 Deep Run Road 21160 items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 X Yes 2 No 1968—
If Yes, Give
Year or Dates. 1974 Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 - Widowed 4 - Divorced Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Erickson Constr. Elementary/Secondary (0-12) College (1-4 or 5+) Construction Superintendent — Field Operations Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Chester Moore, Sr. Loretta McDonnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Karen Moore (Spouse) <u> 1705 Deep Run Road, Whiteford, Maryland 21160</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State emetery, crematory or other place)

November 05,
Church Cametery

November 05, 1 X Burial 2 Cremation 3 Removal from State St. 4 Donation 5 Other (Specify) Pylesville, Maryland of funeral Service Licenses Jeffrey R. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services - Bel Air Testerman 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1/ Enter he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Nd disease or condition Medical resulting in death) Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the ail 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed? certificate 2 🗌 No 2 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral c 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending hours after death.
uneral Director: At 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined า 24 hours ar ne Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar University

31. Date filed (Month, Day Year)

Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 1000 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Himore 101 6. Sex 1 M 2 □ F If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Country) **Director** Usual Residence of Decedent fshov 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or ocation "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21127 5 4414 MOUNTAIN RO 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify. If Yes Give Completed 3 Widowed 4 Divorced Year or Dates. 78-85 HITE Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) MATION Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ AROLINE URRAN EDWARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ATRICIA 4414 MOUNTAIN RD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ARUNDEL CREMATORY 10-8-11 4 ☐ Donation 5 ☐ Other (Specify) DODENTION 22. Name and Address of Fability DAUGHERTY FUNERAL HOME 21. Signatur INTAIN RD. PASADENA Part 1. Enter the disease, or shock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrendly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemorrhone anachnoid Ph_sician/ disease or condition resulting in death) Medical Que to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit PROVED BY MEDICALE that initiated events Due to (or as a consequence of) resulting in death) Last CERTIFICATION Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) ☐ Yes ∠∟ ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably 1 Yes 24b. Were autopsy findings available prior to completion of cause of deat/?

1 ☑ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 💢 Yes 🕯 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann r of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred V Natural 5 Pending iniury Accident Suicide Accident Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

SOSPectos

NOV 0 1 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35052 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 12:20 PM November Charles Porter, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia Gilchrist Hospice 8. Date of Birth (Month, Day, Year If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours Min. 88 Maryland Director Feb 4 216-18-4281 Usual Residence of Deceden 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location items 23a or 28a-f sho ner must be notified at Director 1 XYes 2 No Ellicott City Howard Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21042 4025 Jav Em Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? 1 $\sqrt{1}$ Yes 2 $\sqrt{1}$ No If Yes, Give Year or Dates. $\sqrt{1}$ Black, White, etc. 6 ģ 1 Never Married 2 Married er than "natural", the Medical Exan 1 ☐ Yes 2 🕅 No Specify: White 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry filed within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government <u>Postal Carrier</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ျ Department of Health and Ment. Important: If item 27 is markend any injury or other. Catherine Stockman Lemuel Porter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4025 Jay Em Circle, Ellicott City, MD Leo J. Porter - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 XBurial 2 Cremation 3 Removal from State Meadowridge Mem. Park 11/05/2011 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman F.H. @ MMP 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Marylad 21075 23a. Part 1. Enter the disease, occomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure/List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RENAL FAILURE YEARS Medical resulting in death) **Examiner** DIABETES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami and -transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) g physician a s the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown EMPHYSEMA Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No CORONARY ARTERY DISEASE 24a. Was an autopsy performed? Yes 2 X N or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1: Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin work? 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and Hit 29d. Date signed (Month, Day, Year) D64395 NOVEMBER1, 2011 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

DANIEWE DOBERMAN, MD 6336 LEBAR LANE COLUMBIA, MIS 21044 BY1 V

State Registrar

Maryland 21215-0036

Baltimore,

68760

Box

P.0.

Records,

of Vital

Division

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Market Amend Items 23aPt1,2	aryland / De 5 per me	epartment of \$921 117 ertificate of	f Health and I 02/2011dhb f Death	Mental Hy	giene _{Reg. No.} 2 ()	35053
	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea		3. Time of Death
	Medic	al	DONALD, Preece				October	4	2011 1920 M
	Examin	er	4a. Facility Name (if not institution, give street and number) University of Marryland Medica	nation)	0 111	, or Location of Death		4c. Count	y of Death
	Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthda	y) If Under 1 Ye		8. Date of Birt		9. Birthplace (State or Foreign
	Director			64 _{Yrs}	Months Day	ys Hours Min.	reb. 19	, Yer 947	Baltimore, MD
	nd how at	ž	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	/anyla 8a√f s tified	ect	MD Worcester	Be:	rlin				1 🗆 Yes 2 🛣 No
	a or 2 be no	٥	10e. Street and Number		10f. Zip Cod				What Country?
	th with ms 23 must	Funeral Director	3 Camelot Circle			1811		United S	
0	er dea or ite niner	by Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent E Armed Forces? 1 Yes 2	ver in U.S.	If Yes, specify C	f Hispanic Origin? (Sp uban, Mexican, Puerto	Rican, etc.)		ce - American Indian, ack, White, etc.
21215-0036	ırs aftı ıral", I Exar	edb	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.		1 ☐ Yes 2 🔀	No Specify:		Specify	w White
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77	rithin 7	Completed	Elementary/Seconday (0-12) College (1-4 or 5		e. DO NOT use retire liœ Offiæ			Baltim	ore City
ק	illed will Hygi	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	ne (First, Middle,	Maiden Surnam	ne)
ylaı	ld be Ments iarkec	2	Joseph M. Preece		_	Ada Smit	n 		
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Barbara Preece- Wife	19b. M 3 C	ailing Address (Stre anelot Cin	et and Number or Rur le Berlin, N	al Route Numbe /aryland 2	r, City or Town, 1811	State, Zip Code)
Baltimore,	pe 1 an t of He If item or oth		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dis	sposition (Name of cremeton of Status	olace) Octo	Date Der 11,		- City or Town, State
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pa	permii Depar Impor any in	9	21. Signature of Funeral Service Licensee	M	Evans Funer 8800 Harfor	dres of Facility al Chapel & d Rd. Parkvi	Cemetion Le, MD 2	Services 1234	;
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	icate be executed g physician and is the burial-transit	dical Examiner	resulting in death) Last Due to (or as a	consequence of):		CERTIFICATION MOPPIC	MED		
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POX	death ne atte ed for	sicia	1 Yes 2 No 4 Pregnant at		3 ☐ Ectopic pregn 5 ☐ Other (specify)	ancy		M	onth Day Year
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5 1	nding ath. r: Afte e fune	icate	1 V Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation	Year) injur	y w	ork?	Zod, Describe II	ow many booti	100
UNISIOU :	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hourst death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injur building, etc.	y - At home, farm, (Specify)	street, factory, offic	e	28f. Location (S City or Tow		ber or Rural Route Number,
ָׁב	ospital hours uneral ed filled	Medical	29a. Certifier 1 Certifying Physician: To the best of r (Check 2 Medical Examiner: On the basis of ex	ny knowledge, dea	th occured at the ti	me, date and place, a	nd due to the car	use(s) and man	ner as stated.
:	the H thin 24 the F mplete		only one) 3 Certifying Nurse Practioner: To the b		e, death occurred a	the time, date and pla	ce, and due to the	e cause(s) and m	nanner as stated.
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7			30. Name and address of person who completed cause of de	ath (Item 23a) (Type		6246598	. ا	October	2, 4, 2011
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	Stat Registra			's Signature					
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 ATHERINE October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 2902 WINCHESTER WAY FALLSTON, MO If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 👿 F Months Days Hours Min. (Month, Day, Year May 08, 91 219-07-1744 Director Usual Residence of Decedent "natural", or Items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f shoi any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director Fallston Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21047 2902 Winchester Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 XWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Cadwallader Cora Cessena 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Crocetti (Daughter) 2902 Windester Way Fallston, Maryland 21047 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date November 02, 2011 1 XBurial 2 Cremation 3 Removal from State Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cerretery 21. Signature of Funeral Service Licen Name and Address of Facility
Exans Funeral Chapel & Chematica Services Parkville
8800 Harford Road Parkville, Maryland 21234 O 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or that failure, List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) EMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical of Vital 26. Place of Death (Check only one) examiner (Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at To the Hospital or Attending P within 24 hours after death.
To the Funeral Director: After t Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Division 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 3 🗖 29b. Signature and title of certifier 29c. License number 1174577522

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between

Onset and Death

H

1 🗌 Yes 2 💢 No

Maryland

White

5:30 PM

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 11-1-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KENWOOD AUE-BALTO, MD 21237 32. Registra s Signatur State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Von Month Physician/ 12:16 AM 2 g 2011 William Henry Powers 10 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs, last birthday) **Funeral** 1 🌠 M 2 🗆 F 5Ó Months Augus 221^{Yea} 1961 North Carolina 240-23-3862 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at North Funeral Director 1

Yes 2 ☐ No Carolina Lullington Harnett 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 0 U.S.A. 27546 23a1208 Summerville Mamers Road or items Was Decedent of Hispanic Drigin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Was Decedo... Armed Forces? - Yes 2 \(\hat{\Delta}\) No r Heath and Mental Hygiene. item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner. Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tire Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ida Geraldine Morton Robert Powers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 Wildlife Road, Lillington, North Carolina 27546 Kari Redding 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date Department of I-Important: If ite any injury or ott cemetery, crematory or other place) HarnettRegionalCrematory10-30-11 Lillington, NorthCarolina 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 Margulli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 days Physician/ Anoxic brain disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Severe my ocardial Sequentially list conditions, Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Dther (specify) Pregnant at time of death Yes 2 No 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 1 Yes 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after de To the Funeral Directo completed filled in by the determined City or Town, State) Medical 1 Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: Do the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/28/2011 AT 2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21218 parkenay 201 East University

√ DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

NOV 0 3 2011

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mpm-28-2011 10:30 A M Physician/ Rattell Theresa Rita Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Catonsville Charlestown Nursing Home If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Country) MD Funeral 1 M 2 X Months Hours (Manth Day, Year) 21 90 214-14-9340 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10a. State 10c. City, Town or Location 10b. County death with the Maryland Examiner must be notified at Director 1 Yes 2 No Catonsville MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral items 23a 21228 United States 709 Maiden Choice Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 0 1 Never Married 2 Married ò Maryland 21215-0036 filed within 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. White 3 Widowed 4 ☐ Divorced "natural", Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 2 Sophia M. Wiegand August A. Flaig 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4319 Spring Avenue, Halethorpe, Maryland 21227 Robert P. Rattell - son 3altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10-31-2011 1 X Burial 2 Cremation 3 Removal from State Elkridge, Maryland Meadowridge Memorial Park 4 Donation 5 Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home at Signature of Funeral Service MMP, Inc, 7250 Wash. Blvd., Elkridge, Md 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ nd Stage disease or condition Medical resulting in death) Due to (or as a con uence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year 5 Other (specify) Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 Probably 4 Unknown neunonia 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical filled in by the funeral director, Certificate: To Be examiner? 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4. Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at work? iniury Natural 5 Pending 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 3 🗆

DHMH 17 Rev 7/2009

State

29b. Signature and title of certifie

30. Name and address of

Catous Ville

MO

10 erson who completed cause of death (Item 23a) (Type, Print)

> CN. 32. Registras Signa

29d. Date signed (Month, Day, Year)

11-07871 Walter T. Rice Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

raiter 1. Rice		1- For State Registrar	State	e of Maryland	•	tment of I ficate of L		nd Ment	al Hygiene	Reg. N	201	1 350	00
Physicia ledical Exami		1. Decedent's Name ((First, Middle,La						2. Date of De Month	eath Day	/ Year	3. Time of Death	_
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Funeral Director		5. Social Security Nur 255-50-23 Usual Residence of D	310 12	Sex 7. Ag	e (In yrs. last	birthday) Yrs.	If Under 1 Year Months Day		Min	1	Fore	Birthplace (State or eign Count ⊗ EORGIA	_
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K 68 certif	Cian	past 12 months?		1 Live birth Pregnant at	time of death	2 Fetal	death 3 [(Specify)	Ectopic p	oregnancy	- H	Month	Day Year	
Box 6876ine death certificate the attending phyned for use as the t	Physician/I	1 Yes 2 No		9 Unknown									
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ding P ding P h. After		27. Manner of Death 1 X Natural 5	Pending	28a. Date of Injur (Month, Day,Ye	y 28 ear)	b. Time of Injur	1 _	ry at Work? ∕es 2	28d. Describe	how in	jury occurred		
isio Atten er deatl rectur; by the	Certification:	2 Accident	Investigat	29a Blace of Ini	urv - At home	farm. street. f				(Street	and Number or R	ural Route Number, City	v
Dital or or a start of the control o	=	3 Suicide 6 4 Homicide	Could not determine	De	•	, , , .	,,		or Town,				,
To the Hus within 24 hc Tn the Fun completely i		29a. Certifier 1 C	rtifying Physic	ian: To the best of my	knowledge,	death occurred	at the time, da	ate and place	e, and due to the cau	ise(s) a	nd manner as sta	ited.	
To the within Th the comple	8 L	29b. Signature and title		and manner stated.	iii ation andre	n investigation	29c. License		arec at the time, date	-	Date signed (Mo		
	1	5-7)				O.C.N			1 .	tober 22, 201		
4		30. Name and address	of person who	completed cause of de	eath (Item 23a	1)			_				
W	1	Donna M. Vino		Assistant Medica		er 900 W	Baltimore	Street, B	Baltimore, MD 2	1223			
Sta Registr	_	31. Date filed (Month, E	Day, Year)	32. Registrar	s Signature	_4							
HMH 17 Rev 1/200		NUV U 3 2	U11 /	eneur B.	1900	RIGINAL							_
OCME 2006			OCN	E									

DHMH 17 Rev 1/2001 OCME 2006

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_	State of Marylan									
	_	_ State Registrar		Cer	tificate o	f Death			eg. No. 2		-35	058
Physicia	n/	1. Decedent's Name (First, Middle, Last) Virginia B.	Ruxton					2. Date of Deat OCt. 30), ^D 2 7011	Year	3. Time of 7:54	Death A M
Medica Examine		4a. Facility Name (if not institution, give stre			4b. City, Tow	n, or Location of	f Death	000. 00	4c. County	of Death	1.7.0	
)	•	1900 Eastland R	oad		,	Ruxto				Balt	imore	
Funeral		5. Social Security Number 6. Sex 168-28-1526	7. Age (In yrs. Ia		If Under 1 Ye Months Da		24 Hrs. Min.	8. Date of Birth June 24	Year) 1 0 3 1		lace (State o try) Sylvan	
Director		Usual Residence of Decedent		80 Yrs.				oune 2-	, 1551			
yland -f sho ed at	cto	10a. State 10b. County		, Town or Lo						1	0d. Inside Ci	ty Limits
or 28a	Dire	Md. Baltim 10e. Street and Number	ore		Rt 10f. Zip Cod	uxton _{le}		1	10g. Citizen of V	Vhat Cour		2 225 110
s after death with the Maryland ral", or items 23a or 28a-f show Examiner must be notified at	Funeral Director	1900 Eastland R	oad			21204				SA		
death items ner m		Tr. Martar Status	Was Decedent Ever in U.S Armed Forces?	3. 13. V	Vas Decedent of Yes, specify C	of Hispanic Orig Juban, Mexican,	gin? (Spec , Puerto R	ify Yes or No- lican, etc.)		e - Americ k, White,	an Indian, etc.	-
s after al", or Exami	pd by	1 ☐ Never Married 2 ☐ Married 3 🕱 Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1	☐ Yes 2ሺ	No Specify:			Specify:	Wh	ite	
be filed within 72 hours after death with the Maryland antal Hygiene. ked other than "natural", or items 23a or 28a-f sho c event, the Medical Examiner must be notified at	Completed	15. Decedent's Educa (Specify only highest grade of	ition		lent's Usual Oc	cupation ne during most	of workin	g I	16b. Kind of Bu	usiness In	dustry	
thin 7%	Jon J	Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	O NOT use retii	^{red)} omemake)				Own	Home	
iled wi I Hygid other rent, t	Be	17. Father's Name (First, Middle, Last)	<u> </u>					(First, Middle, N	Maiden Surname		1101110	
ld be f Menta arked atic ev	은	John	Brandt				N	Mary		Tayl	or	
2 shou h and 7 is m traum:		19a. Informant's Name/Relationship (Type,	,						City or Town, S			353
I and the Healt them 2		Philip T. Ruxton/ 20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of			ate ROCKV	ille, Ma 20c. Location -)55
Page nent o ant: If ıry or		1 ☐ Burial 2 K Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)			natory or other Service	Corp.	11/3/	/11 -	Towson,	Mary	/land	_
permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natuary injury or other traumatic event, the Medical once.		21. Signature of Funeral Service Licensee	1/0/						n Funer			1C.
□ □ = # 0	-	23a Part 1 Enter the disease or complete	tions that caused the feat						aryland	2120	J4 Approximat	te.
Physician/		23a. Part 1. Enter the disease, or complete shock, or heart failure. List only die commediate Cause (Final	ause on each line.	اء معما	Lunc	Sign A	dune	prancin	oma	۱,	Interval Bet Onset and	ween Death
Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ	ience of):	June	C Was a second			-	-	THE Y	<u>- u v</u>
4	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequ	ience of:					· ·	-		
uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	Dae to (o) as a sonocqu	.01100 017								
sician and burial-transit	cal Ex	that initiated events c. resulting in death) Last	Due to (or as a consequ	ience of):								
		d. ,	-									
eath certificate be attending physist for use as the b	Ž/	IF FEMALE: 23b. Was decedent pregnant 23c	. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta		Ectopic pregi	2000			23d. Da	te of deliv	rery	
death he atte ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ♣ No 9 ☐ Unknown	4 Pregnant at time of c		Other (specif				Mo	nth	Day	Year
es that the dessigned by the s	Ph/	Part II. Other significant conditions contri	buting to death but not res	ulting in the u	nderlying caus	e given in Part I	l.	23e. Did to	bacco use cont	ribute to t	he cause of c	death?
uires the n signerally be	ed by			-				1 💢 Y	es 2 🗆 No	3 🗆 Pro	bably 4 \square	Unknown
aw requires as been sig 2 should b	Completed							24a. Was a	sv	prior to co	psy findings empletion of o	available cause of
The law cate has page 2 s								perfor 1 Yes	med? 2 X No	death?	2 🗌 No	
sician: The certificate irector, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	pital:	FD/Out-ation		Other:	`		ence 6 🗌 Oth	or (Coosif		
ig Phy ter this neral d	te: To	27. Manner of Death	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c.	njury at vork?			ow injury occurr		<u>y) </u>	
tendir death. tor: Af the fu	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 Yes 2					/ D	
Ior At after o Direct	Cert	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		eet, factory, off	ice	2	28f. Location (Si City or Town	treet and Numb n, State)	er or Rure	ii Route Num	ser,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	Medical		n: To the best of my know	ledge, death	occured at the	time, date and p	place, and	d due to the cau	ise(s) and mann	er as stat	ed.	anner stated
thin 24	Me	only one) 3 Certifying Nurse P	ractioner: To the best of m	y knowledge,	death occurred	at the time, date	and place	e, and due to the	cause(s) and m	anner as s	tated.	
5 ≥ 6 ⊗		29b. Signature and title of certifier	Levene.	M.D.	296. 110	1787	13	1	B chale	v 3	1,201	1
10		30. Name and address of person who com	pleted cause of death (Item	23a) (Type, F	Print)	1	<u> </u>	1 6 1	Tuws	, , ,	MDO	1761
10		Manshall A. Le	VINE 6560	ture		naries	Dui	He 201	(U WS	رام	1-10 2	-1204
Stat Registra		NOV 0 3 201	1 Sum	1. 4	arkel							·

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State of Maryland / Department of Health and Mental Hydiana

			For State Registrar	State of Ma	aryland	-	artment of I tificate of I		and N	-		001		F0F0
ı			Decedent's Name (First, Middle, Last	st)	Henry					2. Date of De	Reg. No.	2 U T	3. Ti	me of Death
	Physicia Medic		Henry Geral	d Reik	215					Month	Day 27	Year	1-	340 PM
	Examin		4a. Facility Name (if not institution, give				4b. City, Town, o	r Location	of Death	, <u> </u>	4c. C	County of Dea	th	
· parent			743 Pine Valley						no1d			Ann	e Aru	nde1
	Funeral Director		111-32-1110	ex 7. Age	70	st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Birl (Month, Da 09/16/	th y, Yea <i>r)</i> 1941		rthplace (S ountry) N	tate or Foreign Y
	ind show at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	cation						10d. Insi	ide City Limits
	fanyla Ba-f s tified	Funeral Director	MD Anne A	rundel			G	len B	urni	_				∵Yes 2 X XNo
	or 2	ă	10e. Street and Number	1011401			10f. Zip Code	Glen Burnie Zip Code 10a. Citizen of What Country?						
	with s 23a ust b	era	208 Phelps Aver	ıue				210	60			U	.S.A.	
	death item		11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	13. V	Vas Decedent of F Yes, specify Cub	lispanic Or	rigin? (Spe	cify Yes or No-	14	4. Race - Am	erican India	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	- 1	Yes 2X No			nican, etc.)	Sį	Black, Whi	te, etc. White			
2	"2 hot	ple	15. Decedent's E (Specify only highest gra	ducation ade completed)	Į	16a. Deced	ent's Usual Occup aind of work done	oation during mo:	st of worki	na	16b. Kind	d of Business	Industry	
12	ithin 7 ene. • than he M	Son	Elementary/Seconday (0-12)											
2	ed wi Hygi other ent, t	Be (17. Father's Name (First, Middle, Last)	4			Engi	neer	noric Name	e (First, Middle,	Maidan Su		neeri	ıng
<u>a</u>	ould be filed within 72 hour: Id Mental Hygiene. marked other than "natur matic event, the Medical	မ	Henry G. Riekers	3				1	i1een			11amo:	re	
ary	should thand Me is mar raumati		19a. Informant's Name/Relationship (7)			19b. Mailin	g Address (Street		·				-	
	and 2 s Health a tem 27 i		Mr. Gerald Scott R	Riekers / s	son	129	Hunting					er, P		602
Baltimore,	age 1 and 2 should be int of Health and Ment t: If item 27 is marked r or other traumatic		20a. Method of Disposition 1 ☐ Burial 2 🎇 Cremation 3 ☐	Removal from State	20b. Pl	ace of Dispo	sition (Name of natory or other pla	ce)	[Date	20c. Loc	ation - City o	r Town, Sta	ate
Ē	. Pag tment tant: jury o		4 Donation 5 Other (Special		Ι.	antic	Cremator	y		9/2011		Burn	ie, M	aryland
eg Ra	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		21. Signature of Funeral Service Licens	see			. Name and Addre							ie, MD
			23a. Part 1. Enter the disease, or com	plications that caused	MO1		ngleton					Service		
	Dh. sisis/		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line							est,		Interva	ximate al Between and Death
	Physician/ Medical	1	disease or condition resulting in death)	a. Due to (or as a	Canc	erw	ith live	1 me	tas-	ta Sis				year
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		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	conseque	ence of):								
	cuted nd ransit	cam	Cause (Disease or iinjury that initiated events	c										
	e exection and an animal-t	al E	resulting in death) Last	Due to (or as a	conseque	ence of):								
9	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		d										
000	ertific ding p		IF FEMALE:	23c. If yes, outcome of	of pregnan	CV								
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	the de y the iched	Physician/M	1 L Yes 2 L No 9 L Unknown	9 🗌 Unknown			(0,000,000,000,000,000,000,000,000,000,							
י כ	that t ned b e deta	by P	Part II. Other significant conditions of	ontributing to death bu	t not resu	lting in the u	nderlying cause gi	ven in Part	t I.	23e. Did to	obacco use	e contribute t	o the caus	e of death?
S)	quires an sig uld bi					-				1 🗆	Yes 2 🗀	No 3□F	Probably	4 🖾 Unknown
ecords,	aw rec as bee 2 sho	plet								24a. Was		24b. Were at	utopsy find	lings available
ב ב	ding Physician: The law require h. Affer this certificate has been si funeral director, page 2 should	Completed								autor perfo	rmed?	death?	s 2 🖾 N	
VILA	cian: ertific ector,	Be (25. Was case referred to medical examiner?	Hanning To State of the State o				lace of Dea	ath (Check		22			
>	Physic this c	<u>۵</u>	1 ☐ Yes 2 ☒ No 27. Manner of Death			R/Outpatien		<u>4 ⊔ N</u>	lursing Ho	me 5 🔀 Resid	dence	Other (Spe	Dau Res	ighter's idence
IVISION OF	ding h. h. After funer	Certificate:	1 🔼 Natural 5 🗌 Pending	28a. Date of injur (Month, Day,		28b. Time of injury	28c. Injur worl	</td <td>- 1</td> <td>28d. Describe h</td> <td>ow injury o</td> <td>occurred</td> <td></td> <td></td>	- 1	28d. Describe h	ow injury o	occurred		
200	Atten dest ctor y the	Ĕ	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not b		v - At hon	ne farm stre		Yes 2	\longrightarrow	28f. Location (S	Stroot and I	Viembor or De	wal Pauta	Number
2	alor/ seffer il ire		4 Homicide determined	building, etc.	(Specify)	io, iaiii, bire	or, ractory, ornoc			City or Tow		vurriber or no	nai noute	Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Unector After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 L. Medical Exami	sician: To the best of r ner: On the basis of ex se Practioner: To the b	amination	and/or invest	gation, in my opini	on, death c	occurred at	the time date a	nd place, a	nd due to the	cause(s) ar	nd manner stated.
	To th Withir To th COMP	<	29b. Signature and title of certifier		. So. Or my	omeage, a	29c. Licens		овно рівс	o, and due to th		signed (Mont		ar)
			1/ mobil	MP			069	156	6	1	10/	27/11		
/			30. Name and address of person who c		ath (Item 2	23a) (Type, P	rint)	,						
			Ivelisse Mici				1 Park	Wal	1 11	nnapa	2115	MO	214	101
	Stat Registra	_	31. Date filed (Month, Day, Year) 1	Registra	's Signatu	Bar	J							
			NUY U J ZULI	I WALLEY	A 1	Name and Add on the								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ella Mae Ross 10:35 October 2011 P. M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore ManorCare Woodbridge Valley
5. Social Security Number 6. Sex Catonsville Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 5-1927, Year) Months Davs Hours Min. <u>212-34-27</u>80 84 **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director ams 23a or 28a-f shir must be notified a 1 XYes 2 No Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code Funeral USA 21217 1600 W. Mount Royal Avenue # 603 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status ural", or iten | Examiner r Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: African-American "natural" Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Security 11th lith and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Lugenia Spence Andrew Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9828 Lyons Mills Rd., Owings Mills, MD 21117 of Health a Adrienne D. McGuire/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 \square Cremation 3 \square Removal from State Department of Important: If it any injury or conce. Owings Mills, MD Garrison Forest Veterans 11-7-2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility lie Funeral Hone P.A. of Balto. Co. 21. Signature of Funeral Service Ligense 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final CELL CARGNOMA OF TONGUS Physician/ >QUAMOUS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a densequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? bate has been signed bage 2 should be det Be Completed by CARDINVAS CULAR DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician; 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 5 \square Pending after death. 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar CENTER PHVE, REISTERSTOWN, MD 21136

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

210

BUSINESS

Maryland 21215-0036 Baltimore. Box 68760 P.O. Records, law Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1- State of Maryland / Department of Health and Mental Hygiene Registrar

State of Maryland / Department of Health and Mental Hygiene me, g921, 11703/2011 dnb 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Annie Louise C. Rouleau 4:05 P. November 01,2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore County Gilchrist Hospice Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2 🔀 F Director 216-20-4708 85 Nov. 15, 1925 Troutville, VA. Usual Residence of Decedent 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore County Glen Arm 1 Yes 2 No 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11630 Glen Arm Road 21057 United States items 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 ģ 1 Never Married 2 Married 1 Yes If Yes, Give 2 **X**No 72 hours after 1 Yes 2 No Specify White Specify: "natural" Completed 3 X Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Elementary School Teacher Public Schools 12 04Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname မ Everett Coffman Ruth Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Mr. Robin Michael Rouleau (Son) 21234 9243 Smith Ave. Parkville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sat. Location - City or Town, State (Baltimore County) 1 Burial 2 Cremation 3 Removal from State Sherwood Epis.Ch.Cem. Nov. 05,2011 Cockeysville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Leffrey L.Cair, Sr. OSP Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A.

Lic.#00677 235 York Road Timorium, Maryland 21093-2215 23a. Fort 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examir -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical the as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 Yes 2 Unknown the detached Unknown signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 Yes 2 No 3 Probably 4 Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? Yes 2 No 1 Yes 2 No Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Wish 4 this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 **X** No Certificate: 28b. Time of 28d. Describe how injury occurred After Hospital or Attending UNC M Natural 5 Pending Probable fall 2 Accident 104 PE 1201 the Investigation within 24 hours after deatl To the Funeral Director. Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) **Assisted Living** 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11650 Clen Anm RD, Clen Alm M completely filled in by determined CKM ARM MO items Facility Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number NORWISED 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 vonles ST prison mil N HANGE 32. Registrar's Signature 31. Date filed State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylar			nt of H e of D		and M	lental Hyg	7	011	35062
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	Medic	al	4a. Facility Name (if not institution, give	uths	a ul		I				10	31 "	Year 2011	1:50 PM
	Examin	er	Baltimore Washing		,	enter	4b. City	Town, or I	Location o en Bu				ty of Death ne Aru	ınde1
	uneral		5. Social Security Number 6. Se	x 7	. Age (In yrs. I		If Unde	r 1 Year	If Under		8. Date of Birth		g. Birthp	olace (State or Foreign
	rector		218-01-8222 11 Usual Residence of Decedent	X M 2 □ F		91 Yrs.	Wonths	Days	nours	IVIIII.	Aug. 03	1920	Coun	MD MD
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Z1Z15-0036 vithin 72 hours after jiene.	atural cel Ex	Completed	3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Ed	Year or Date	es.							Specif	,	
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ge 1a nt of H	or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐			Place of Disposemetery, crem	sition (Nai natory or c	me of other place)	Nov.	oate 05	20c. Location	- City or To	own, State
baltimore, bermit. Page 1 and Department of Hea	ortant injury e.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Doeses		G1	en Have		emete:						, Maryland
Dep de	any		Ild Si	ll r		22				~	Road, Pa			ome, P.A. 21122
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Phy of	neral c		27. Manner of Death	28a. Date of		28b. Time of injury		28c. Injury : work?	at		me 5 Resider 28d. Describe how			9
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours are reseth.	unera ed fille	Medical	29a. Certifier 1 Certifying Physi (Check 2 Medical Examin	cian: To the bes	t of my know	edge, death o	ccured at	the time,	date and p	olace, and	due to the caus	e(s) and man	ner as state	ed.
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i		ŀ	30. Name and address of person who co	moleted cause	of death (Item	23a) (Type, P	rin _t)	000	680	1/6	()	10/3		1
1			7. Berhane	MIN.		301 /	105/	pite	1 1	Dr.	Gler	Dur	nip	21061
R	Stat egistra	e ır	31. Date filed (Month, Day, Year) NOV 0 3 2011	32. Reg	istrar's Sanai	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $NOVEMBER \stackrel{Day}{0}1$, Physician/ RUDO 1:01 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 3440 ASSOCIATED WAY, OWINGS MILLS BALTIMORE If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours **Director** 250-16-8489 1 □ M 2 🛛 F 07/07/1920 SC 91 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** must be notified 1 Yes 2 X No MD BALTIMORE OWINGS MILLS 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a 3440 ASSOCIATED WAY, 21117 ral", or items a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give "natural", 3 X Widowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည marked Health and Mentitem 27 is marked the traumatic e BENJAMIN WOLFSON **PHOEBE** BOAZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENJAMIN RUDO/SON SIMPSON COURT, REISTERSTOWN, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State artment of Hortant: If ite 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/02/2011 BALTIMORE, MD permit.
Der artm
Imports
any inju 21. Signature of Juneral Service License SOL LEVINSON & BROS., INC. wells 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one car that caused the death. Do not Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) as a consequence of): Examiner 101161 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequent Cause (Disease or injury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical I or Attending Physician: The law requires that the death certificate be after death. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ the atter Live Birth 2 L retail usual Pregnant at time of death in the past 12 months? Day Year 1 Yes 2 9 | Unknown significant anditions for ributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2: autonsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 A No Hospital Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident neral Director: A 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined Hospital Medical 29a. Certifier 🗪 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat and title of certifier 29d. Date signed (Month, Day, Year) hame and address of person who completed cause of death (Item 23a) (Type 2/208 Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Year FLLEN SCHULTZ 0445 AM OCT 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITA COLUMBIA HOWARD COUNTY Social Security Number 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MD Months Hours 10-06 1916 Director 220-07-2904 95 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertial Hygiene. Misportant: I firem 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carroll Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 7600 Jenn Drive 21797 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give 3 ₩Widowed 4 □ Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Fenmore Cooper Dove Edith Bassford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8429 Lockwood Road, Lake Shore, Maryland 21122 William F. Schultz - son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem Park 11-04-2011 Glen Burnie, Maryland 21. Signature of Funeral Service Lice 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc.7250 Wash Blvd, Elkridge, MD 21075 23a. Part (Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Onset and Death Physician/ CONGESTIV HEART FAILURE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions Examiner cause. Enter Underlying I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit CARDIOMYOPATHY Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 u a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 No 1 Yes Division of Vital Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending iniury 1 Natural 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

11085 Little Patuxent PKWY, suit LOOI, MYTHILY VANCHA 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Mythily

29c. License number

D0064760

29d. Date signed (Month, Day, Year)

OCT, 31, 2011 Medical Acts Building

COLUMBIA, MD - 21044

DHMH 17 Rev 1/2001 OCME 2006

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Antoinette Josephine Svatora October 29 2011 1:15 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Stephen's Green Timonium Baltimore 8. Date of Birth (Month, Day, Year) Aug. 7 1914 Social Security Number If Under 1 Year If Under 24 Hrs. Birthpic Country) MD . Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 F Hours Director 215-22-5830 97 Usual Residence of Decedent show 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director or 28a-f sl 1 🗌 Yes 2 🙀 No MD Baltimore Timonium 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2525 Pot Spring Road #DC5 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner 0 ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify "natural", Specify: white Completed 3 X Widowed 4 Divorced Year or Dates d Mental rayson, marked other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N n/a Medical <u>dministrative Assistant</u> 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Albert Svec Josephine Moravec 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Bartenfelder/daughter 10813 Lakespring Way, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 11 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) of Faith Cem. 11/2/11 Balto.. 21. Sign ture of Funeral Servic Livense. Lemmon Funeral 10 W. Padonia Home of Dulaney Valley, Inc. Rd., Timonium, MD 21093 Flag1e Micheal J. W. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ voice Medical resulting in death) Due to (or as a co Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the Hospital or Attending Physician: The law requires that the death certificate be executed and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No g 🗌 Unknown detached g 🗌 Unknown Division of Vital Records, P.O. ò Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by director, page 2 should be 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' this certificate 1 Yes 2 No Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence & Other (Specify) 2X No မ 1 Inpatient 2 I ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this of completed filled in by the funeral director. 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical L Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

29b. Signature and title of certifier

3p. Name and address of pers

NOV 0 3 2011

m 23a) (Type, Print)

pleted cause of death (I

32. Registrar's Sign

29c. License number

2011

ctober

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Kol MILDRED Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Randallstown Season's Hospice 8. Date of Birth (Month, Day, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 219-60-3211 MD Director 1 □ M 2**X**F March 19, 1952 59 Show 10d. Inside City Limits 10c. City, Town or Location 10b. Count at Director or 28a-f sh notified 1XX Yes 2 \sum No Baltimore MDN/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number to f Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or If item 27 is marked other than "natural", or items be not the Medical Examiner must be not the mus U.S.A. Funeral 21211 3000 Keswick Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S 11. Marital Status Black, White, etc. Armed Forces?

1 Yes No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 XXDivorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Klob Thomas Ivins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1413 Roland Heights Avenue Balto, MD 21211 Arlon Sitterly (Son) Method of Disposition

1 → Burial 2 □ Cremation 3 □ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot Page 1 Lorraine Park Cenetery Baltimore, MD 11/4/11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Balto,MD 21211 Signature of Funeral Service Licenses Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_ysician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Physician/Medical P.O. Box 68760 as 1 IF FEMALE: ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Por in the past 12 months' 1 Yes 2 No Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has b lirector, page 2 s performe Yes 2 25. Was case referred to ___dica 26. Place of Death (Check only one) Be examiner? 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 0 28a. Date of injury (Month, Day, Year) 27. Manne eath 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: atural injury 5 Pending 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Accident Investigation 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3

State Registrar 29b. Signature and ti

Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 28 28 2011 03:15 АМ John Joseph Schollian Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Anne Arundel Tate Hospice House Linthicum If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 214-22-8619 Director 1 X M 2 □ F 83 Yrs. Jan. 30 1928 MD Usual Residence of Deced permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nature!" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Anne Arundel Maryland Glen Burnie 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 408 Glenwood Avenue 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Ves 2 No 1943-If Yes, Give Year or Dates. 1945 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Maryland State Purchasing Agent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ F. John Schollian Marie Μ. Truffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 685 208th Street, Pasadena, MD 21122 Darlene Evans (daughter) Date 29 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 2011 Metro Crematory Inc. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Service Licevisee 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ndications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final Ph_sician/ UNG ANCER VEAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death signed by the at d be detached for g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?
1 ☐ Yes 2 ☐ No has page 2 performed? Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 Natural 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death. 2 Accident
3 Suicide Investigation Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

Registrar DHMH 17 Rev 06-2011

State

within 2 To the F

3 29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

NOV 0 3 2011

7/1 Quan

ss of person who completed cause of death (Item 23a) (Type, Print)

MO 32. Registrar's

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TIEM#10g, 18 per FH, G921, F178/2011, WS is Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 24 4a. Facility Name (If not institution, give street and number) 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 779 medico 1. Kott If Under 1 Year If Under 24 Hrs. 8. LMGIMC 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Date of Birth (Month, Day, **Funeral** Days Hours Min Year. 1 M 2 F COT Director OLOZ-052-1544 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. But: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at Andrews Airforce Base MP. 1 Yes 2 YNo Prince George Co. MD Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number USA Romania Edgebrook Drive Unit 4 20762 4087 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 Who If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Romanuair à 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Petra (unk) Aristidi Romulus Anghelescu 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4087 Edgebrook Drive, Andrews A.F.B., MD 20762 Gabriela Stanciu (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages: Department of h Important: If ite 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Nov 3, 2011 * 4 ☐ Donation 5 ☐ Other (Specify) Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, INc 6633 Old Alexandria Ferry Road, Clinton, MD 20735 Th 14101549 Ker Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due tour as a consequence of): **Physician** NOUN /Medical **Examiner** Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? After t Certification: 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident the 3 🗌 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Division of Vital Records, P.O. Box 68760 Director: To the Hospital or within 24 hours aft To the Funeral Di

> State Registrar

Medical

31. Date filed (Month,

29a. Certifier

(Check only one)

29b. Signature and title of certifier

100

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. F/g

1 Ccrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number

MD 30765

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Detober 11:30 PM **Physician** Wanda Stansbury 24 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Town, or Location of Death Examiner ltimne HOSPITA Months Days Hours Min. August 10,1927 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** West Virginia Months 1 □ M 2 💢 F 235-40-6844 84 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10h. County Wester Known as: Wanda 28a-f show Department of Health and Mental Hygiene important; or items 23a or 28a-1 show important: If Item 27 is marked other than "natural", or items 23a or 28a-1 show amy injury or other traumatic event, the Medical Evant instructs the notified at once. 1 □Yes 2 No Director Webster Cowen Virginia 10e. Street and Number P.O.Box 373 10f. Zip Code 10g. Citizen of What Country? U.S.A. 26206 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Saltimore, Maryland 21215-0036 1 □Yes 2 No ρ 3 →Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ariel I. Bragg Annis S. Goff 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) atent 19a. Informant's Name/Relationship (Type. Print) P.O.Box 332 Craigsville, West Virginia 26208 Randall Barnette - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Oct. 29,2011 Cowen, West Virginia Odd Fellows 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final neumonia veck **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 \ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 🗌 No 2 **N**o 1 ☐ Yes funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 30. Name and address of parson who completed cause of death (Item 23a) (Type Print) 240/W. Belvedere Ane 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Shu bin Day Month Physician/ 15455 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** N/A BALTIMORE 6907 DORSETT PLACE 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** Country 1 □ M 2 🛣 F Director 091-32-6628 NY 09/06/1909 102 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. County Examiner must be notified at Director 1 X Yes 2 No BALTIMORE N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral USA 21215 6907 DORSETT PLACE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 24 No Black, White, etc. "natural", or by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify WHITE If Yes. Give 3 🛱 Widowed 4 □ Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 and Mental Hygiene. College (1-4 or 5+) 5+ Elementary/Secondary (0-12) EDUCATION MUSIC TEACHER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CHADROW MALKA ZIEK TZADDOK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important, If item 27 is any injury or are 6905 DORSETT PLACE, BALTIMORE, MD CARA GANS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition MIFGASH SHAMSHON, 1 X Burial 2 Cremation 3 X Removal from State 11/02/2011 ERETZ HACHAIM CEM. 4 ☐ Donation 5 ☐ Other (Specify) ISRAEL 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine il any, reading to immediate cause. Enter Underlying Cause (Disease or injury Date to for as a consequence offburial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Day 5 Other (specify) Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 Tyes Records, cate has been sig page 2 should b Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 Yes 2 🗌 No Division of Vital filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 🗌 Yes 2 🖊 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of Medical Certificate: 27. Manner of Death 8c. Injury at 28d. Describe how injury occurred 1 A Natural injury 5 Pending 1 Yes 2 🗌 No Investigation Accident 6 🗆 Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier 00 051189

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Mon

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Hypking Bay in Circle

Bultima as 2020

address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 20th per Tring 21, Tiro I 7201 I dealth and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 815 Physician/ nomoso Medical 4a. Facility Name (if not institution, give street and humber) Town, or Location of Death 4c. County of Death 4b. City, **Examiner** Himor 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗹 Months Yrs Director 14-0548 28a-f show 10d. Inside City Limits 10b. County City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State death with the Maryland Director Limore 1 Yes 2 No MJ10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21201 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Blac Specify: "natural", 3 Widowed 4 Divorced Completed the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 bepartment of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Madaconce. Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. 17. Pother's Name (First, Middle, Last, 2 Informant's Name/Relationship (Type, Print) Route Number, Çity or Town, State, Zip Code) 19b. Mailing Address (Street and Number or camo 10 e of Disposition (Name of of Disposition 20b. Place 1 Burial 2 Cremation 3 Removal from State cem 4 Donation 5 Other (Specify) yperal Services e of Funeral Service Lice 15 HWA. MO21133 Roga an 23a. Part 1. Entertile disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mmornage Physician/ abor ach disease or condition Medical resulting in death) Due to (or as a consequence of) #23achエ Fox to mS Division of Vital Records, P.O. Box 68760 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) CERTIFICATION APPROVED BY WELL Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit attending physician and Due to (or as a consequence of): Physician/Medical use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Hospital or Attending Physician: The law requires that the death sate has been signed by the atte page 2 should be detached for Month Day Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗆 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred Found Lying Down in Home, Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 2 Accident 5 Pending 1 Yes 2 No Unknowm 10-21-11 Investigation time Unknown 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1112 Myrtle Ave, Baltimore, MD 21201 Home Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature a title of 10 U4176435 M100777 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month,

0 1 2011

37 Registrar's Signatur

			110000	AMEND TIEM#206, pe State of Maryland / De	rrn, 6921, T1/18/201 partment of Health and N	Mental Hygier	ne
			1 - For State Registrar		ertificate of Death	Reg.	2011 35073
	Physicia	an/	1. Decedent's Name (First, Middle, Las	t)		2. Date of Death	3. Time of Death
	Medi	cal	AL Wyn			10 2	9 11 10 CFM
	Examir	ier	4a. Facility Name (If not institution, give	wan Conter	4b. City, Town, or Location of Death		4c. County of Death But The County of Death
	Funeral		5. Social Security Number 6. Se	7. Age (In vrs. last hirthday		8. Date of Birth	Birthplace (State or Foreign
	Director	6	Usual Residence of Decedent	M 2 F 84 Yrs.	Months Days Hours Min.	(Month Day, Yea	1927 Virginia
	and show	ō	10a. State 10b. County	10c. City, Town or I	_ocation		10d. Inside City Limits
	Maryl 28a-f otifie	irect	ND	Put	imore		1 Yes 2 □ No
	th the 3a or the n	a D	10e. Street and Number	07-0	10f. Zip Code	10g.	Citizen of What Country?
	e filed within 72 hours after death with the Maryland that lygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral Director	154457576NE	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - American Indian,
98	fter de , or it	by F	1 Never Married 2 Married	Armed Forces? 1 Yes 2 □ No If Yes, Give	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
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	ed within Hygiene. other tha		Elementary Seconday (0-12)	College (1-4 or 5+)	uck Driver	- 1	rangeortetion)
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aryli.	should be f and Menta is marked aumatic ev	ľ	19a Informant's Name/Relationship (Tv	De. Print) 19h Ma	iling Address (Street and Number or Rura	1 Pouto Number City	y ar Tayun State Zin Code)
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ore	ge 1 and nt of Heal : If item; or other		20a. Method of Disposition	20b. Place of Dispersion Communication Commu	position (Name of 11/10/ ematory or other place)	20c.	. Location - City or Town, State
Baltimore,	t. Pag rtment rtant: rjury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Distrest Centary T	1/2011 Oc	SingsMill,MD
Bal	permit. Page 1 Department of Important: If i any injury or o		21. Signatur f Funeral Service Livense	101553	Alame and Address OF Vice	ne ture	ral Service
			23a. Part 1. Enter the disease, or comp	olications that caused the death. Do not er	nter the mode and ing, such as cardiac	or respiratory arrest,	Approximate
	hysician/	62 3	shock, or heart failure. List only or Immediate Cause (Final disease or condition		Ner		Interval Between Onset and Death
	Medical Examiner		resulting in death)	a. Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):			
,0,	uted d ansit	Examiner	Cause (Disease or iinjury	and to (or as a consequence or).			
ND	be executed sician and burial-transit		that initiated events resulting in death) Last	Due to (or as a consequence of):			
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687	certific nding parties as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery
30X	death of a ter	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5	Cother (specify)		Month Day Year
P.O. Box 68760	requires that the death certificate been signed by the attending phy should be detached for use as the	Completed by Physician/Med	g ☐ Unknown	g Unknown		1	
ν, σ,	res tha signec I be de	d by	Part II, Other significant conditions co	ntributing to death but not resulting in the	underlying cause given in Part i.		2 No 3 Probably 4 Unknown
ord	requii been should	lete				24a. Was an	24b. Were autopsy findings available
Sec.	he law te has age 2	omp				autopsy performed/	prior to completion of cause of death?
<u>e</u>	ian: T ertifica ctor, p	Be C	25. Was case referred to medical examiner?		26. Place of Death (Check	1 Yes 2 X	No 1 Yes 2 No
Division of Vital Records,	ding Physician: The la h. After this certificate ha funeral director, page	유	1 Yes 2 No	Hospital:		me 5 - Residence	6 ☐ Other (Specify)
0 0	ding I th. After funer	Certificate:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time injury	of 28c. Injury at work? M 1 Yes 2 No	28d. Describe how in	jury occurred
isio	Atter er dea ector by the	ertifi	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s			and Number or Rural Route Number,
<u>S</u>	ital or urs aft ral Dir lled in			building, etc. (Specify)		City or Town, Sta	ate)
	Hosp 24 hor Fune eted fi	Medical	(Check 2, Medical Examin		estigation, in my opinion, death occurred at	the time, date and pla	ace, and due to the cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death certificate within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending phy. completed filled in by the funeral director, page 2 should be detached for use as the	Σ	only one) 3 Certifying Nurse 29b. Signature and title of certifier	e Practioner: To the best of my knowledge	death occurred at the time, date and place 29c. License number		se(s) and manner as stated. Date signed (Month, Day, Year)
	F		PYY	CKIR	RISDZS9	1	0/31/11
	(4)		11	ompleted cause of death (Item 23a) (Type,		RIH	nove MD 21234
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's Signature	20 EMGE Rd	Jalin	MANG IND WICO
	Registra	_	NUV 0 3 2011	Marcus D. Darks	,		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 5:20 Ам **Physician** 1, 2011 November Arthur Wood Raymond /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Genesis-Elder Care - Severna Park Severna Park Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months Hours XXM 2□ F Texas 76 10/7/1935 414-48-0740 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Eracinar must be regimes once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2√XNo Pasadena Director Anne Arundel MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21122 2909 Dungate Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? XX☐ Yes 2 ☐ No If Yes, Give Year or Dates: Black White, etc. 1 Never Married 2 Married Specify: White 1 □Yes 2√CXNo Specify. Maryland 21215-0036 ₫ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zada Frances Clayton James Oliver Wood ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pasadena, MD 21122 2909 Dungate Road Mrs. Rose M. Wood / Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Crownsville, MD MD Vets - Crownsville 11/4/2011 5 ☐ other (Specify) 4 Donation 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySingleton Funeral & Cremation Services, PA 1 2nd Ave SW Glen Burnie, MD 21061 0 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** ment disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician for use as the burial Box 68760 Physician/Medical 23d. Date of delivery 23c. if yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day signed by the a ☐Yes 2☐No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Value of the Specify) 4 Value of the Specify of the Specific of 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Doath After Injury 1 Natural 5 ☐ Pending investigation n 24 hours after death.

e Funeral Director: Aft
bletely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State

DHMH 17 Rev 1/2001

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

86 OI Veterans Mw

7531

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35075 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 3ty, 2014 2:20 AM M Barry Loyd Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A **Baltimore** Gift Of Hope Hospice If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 - F 04716/1945 virginia Director 231-52-0746 66 Usual Residence of Decedent show 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director N/A1 X Yes 2 No **Baltimore** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 818 N. Collington Avenue 21205 death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. , or þ 1 Never Married 2 Married ☐ Yes 2X No Yes, Give 72 hours after Maryland 21215-0036 Black 1 Yes 2 XNo Specify. 3 Widowed 4 Divorced "natural" Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 in and Mental Hygiene. To is marked other than "In it is is marked other than "In it is is marked other than "In it is is it is is in it is it is in it is Elementary/Seconday (0-12) College (1-4 or 5+) N/A Not Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Noward Williams Anna Belle Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau Sr. Vineeth / Caregiver 818 N. Collington Avenue Paltimore, Maryland 21205 Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State mt. Carmel Cemetery 1 XBurial 2 Cremation 3 Removal from State 11/04/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility David J. Weber Funeral Homes PA 401 S. Chester Street Baltimore, Maryland 21231 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Metastatic Physician/ rancheatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Directo (or es a consequence of train, leading to in mediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f g 🗌 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work? 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D18587 OCT 31, 2011

State

Registrar

and address of p

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Williams

Baltimore MD

rson who completed cause of death (Item 23a) (Type, Print)

egistrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9:15 a.M Physician/ 5 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 612 Greenwood Road Pikesville If Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country)
 AT Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 1 X M 2 - F Months AL 235-34-1485 Director Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State Director 1 Yes 2 No Baltimore Pikesville MD 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a or ner must be n ö Funeral 21208 USA 612 Greenwood Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, n "natural", or item edical Examiner n 11. Marital Status Armed Forces? Black, White, etc 1 Never Married 2 X Married þ Spec African-American Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Machanone." College (1-4 or 5+) Elementary/Seconday (0-12) SteelWorker Armco 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Henrietta Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 612 Greenwood Road, Pikesville, MD 21208 Katie Walker/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 11-4-2011 Arbutus Memorial Park Arbutus, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wile Fineral Form P.A. of Balto. Co. 21. Signature of Funeral Service Deensee 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ yoca rdia disease or condition Medical resulting in death) Due to (or f a consequence of): **Examiner** onary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine nsim Cause (Disease or iinjury that initiated events resulting in death) Last betes Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month 5 Other (specify) Pregnant at time of death 1 Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No Adenocarcinoma 1 🗌 Yes 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Dementia To the Hospital or Attending Physician: The law autopsy perform death?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Division of Vital examiner? Other: 4 \(\text{Nursing Home} \) 1 \(\text{X Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be 2 Accident
3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 507+0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Bager St. Baltimore, MD 21202 Vara 1000

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Yeal)

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32. Registrar's Signature

W. Box 68760 (harles) Baltimore, Maryland 21215-0036

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	Physicia Medic		Charles 1	Bell Wi	lhelm						NOVEM	BER D	^{ay} 1 2	Year 0 1 1	11:28 A	
	Examin	er	4a. Facility Name (if not institution, g GREATER BALTIN		CAL C	CENTE		, Town, or	Location FOWS			40	c. County o		MORE	
	Funeral Director	17	5. Social Security Number 476-01-6383	.Sex 1 X M 2 □ F	e (In yrs. Ia	st birthday) Yrs.	If Und Months	Days	If Unde Hours	Min.	8. Date of Bi		9		place (State or Fore htry) tana	ign
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re,	1 and of Hea item		20a. Method of Disposition			ace of Dispo metery, cren	sition (Na	me of			Date Date		_		own, State	
Baltimore, Maryland	Page		1 Burial 2 X Cremation 3			intic	-			11/3	/11	G1er	n Bur	nie,	Marylan	d
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Thous a state of the than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21 signature of Fun ral Service Lio	1 att		22	2. Name a	nd Addres	s of Faci ne ra	ity 1_Hor	ne of D i, Timo	uļan	ey Va	alle	y Inc.	
			23a. Part 1. Inter the disease, or co	mplications that caused	the death								, MD	210	Approximate	
F	Physician/		shock, or heart failure. List onl Immediate Cause inal disease or inon	y one cause on each line	0114	anu I	0								Interval Between Onset and Death	
	Medical Examiner		resulting in death)	Due to k r as	a conseque	ence of):										
		Jer.	Sequentially list conditions, if any, leading to immediate	b. — Due to (or as	a conseque	ence of:								-		
	ecuted and II-transit	Examiner	cause. Enter Underlying Cause (Disease or ilrijury that initiated events													
	an an		resulting in death) Last	Due to (or as	a conseque	ence of):										
68760	cate be physic the b	edic		d												
89	ath certificate be attending physici for use as the bu	M/us	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live Birth			Estania	prognana	.,				23d. Dat	e of deliv	very	
Вох	The law requires that the death certificate be ate has been signed by the attending physic page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant a			Other (s		У				Mor	nth	Day Year	
P. O.	requires that the de been signed by the should be detached	by Ph	Part II. Other significant condition	s contributing to death b	ut not resu	lting in the u	ınderlying	cause giv	en in Par	t I.	23e. Did	tobacco	use contr	bute to t	he cause of death?	
ds,	quires en sign	ed b									1 🗆	Yes 2	2 🗆 No	3 \square Pro	bably 4 Unknown	ówn
Records,	law re nas be s 2 sho	Completed										psy	р	rior to co	ppsy findings availal empletion of cause	ble of
	sician: The law is certificate has be irector, page 2 s		25. Was case referred to medical	10		_		20.51			1 \(\text{Yes}	ormed?		leath?	2 🗌 No	_
Vita	Physician: T r this certifica rral director, p	To Be	examiner? 1 \(\sum \) Yes 2 \(\sum \) No	Hospital:	ent 2 \square E	ER/Outpatier	at 3 🗆 I	Othe	ar.		<i>k only one)</i> ome 5 □ Res	idence	6 □ Othe	r (Specif	v)	-
of	ng fre ine		27. Manner of Death	28a. Date of inju (Month, Da	ry :	28b. Time of injury		28c. Injury work	at	tursing r	28d. Describe	-			//	
ion	ottending F death. ctor: After i y the funera	Certificate:	1. Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	the -	un. At han		M	1 🗆	Yes 2	□ No	006 1	21			1 Decide Number	
Division of Vital	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completed filled in by the		4 Homicide determin	28e. Place of Inju building, etc		ne, tarm, str	eet, facto	у, опісе			City or To			r or Rura	l Route Number,	
	Hospi 24 hou Funer eted fil	Medical	(Check 2 Medical Exa	hysician: To the best of miner: On the basis of e urse Practioner: To the	xamination	and/or invest	tigation, ir	my opinio	n, death	occurred a	it the time, date	and plac	e, and due	to the ca	ause(s) and manner s	stated.
	To the within To the compl	Σ	only one) 3 ☐ Certifying N 29b. Signature and title of certifier	urse Practioner: 10 the	best of my	knowledge, o		c. License		te and pia	ce, and due to t				Day, Year)	
			Mach Jon	ell	Mi)	1	00	85	-08	12	11	1/2	///		
<	LXIV		30. Name and address of person when the same and address of the same address of the same address of the same and address of the same a	o completed cause of d	eath (Item	23a) (Type, F	/	1- Pa	vill	ion	Suite	537	OTO	usc	n, 40	24
H	Stat Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu										,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:53P_M Physician/ Jack Wainglass 1, 2011 Year November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 204 Jumpers Circle Nottingham 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Oct. 13, 1932 MaryTand 218-28-5204 Director 79 Usual Residence of Decedent than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director Nottingham Baltimore MD 1 🗌 Yes 2 🛛 No 10g. Citizen of What Country? Zip Code 21236 by Funeral **USA** 204 Jumpers Circle 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. white 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. Do NOT use, retired) Postal Worker 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. US Postal Service Elementary/Seconday (0-12) College (1-4 or 5+) Ith and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important, If item 27 is marked or
any injury or other traumatic eve Annie Katz Isadore Wainglass 19a. Informant's Name/Relationship (Type, Print)
Rosalie Wainglass-spouse 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Gode, 204 Jumpers Circle-Nottingham, Maryland 21236 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State cemetery crematory or other place)
Evans Funeral Chapel and Nov.6,2011
Cremation Services Belair 1 Burial 2 Cremation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 Approximate Interval Between uset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Cancer disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of: or Attending Physician; The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Artere Disco Division of Vital Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 🛚 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accider Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital evithin 24 hours a To the Funeral D Hospital Medical 1 **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tile of certifie

State Registr<u>a</u>r n Clille

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WATERFIELD

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32. Regist ar's Sign ture

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9103 Frankler &

November

Registrar

State

NOV 0 3 2011

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Dhurio		1- For State Registrar 1. Decedent's Nam	o /Eiret Mid	do Last)		Cer	tificate o	of Dea	ath		2. Date of D	Reg. No	. 20	-	3508
Physicia Medical Exami					lson						Month October		Year 011		3. Time of Death 2233 hrs
		4a. Facility Name (1200 Blk, B			t and numbe	er)			, Town, or L imore	ocation of Dea			c. County of	Death	
Funeral	_	5. Social Security !		6. Sex	7. A	ige (In yrs. la	ast birthday)		imore ider 1 Year	If Under 24H	irs. 8. Date of	Birth(MN	N/A	9. Birt	hplace (State or
Director		213-39-	-9968	1X M :	2 F			Mon			tin		993	Foreign	n untry) MD
any		Usual Residence o	f Decedent			Idon City	Town or Loc	ntion.							10d. Inside City Limits
≥ 1	_	MD	N /				Baltin								1 Yes 2 No
ne Maryland or 28a-f show fied at once.	Director	10e. Street and Nu					Jarcin		ip Code			10g. Ci	tizen of Wha	t Coun	try?
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ath wi	Funeral	11. Marital Status 1 X Never Marri	ed 2 N		Vas Deceder	3?					Specify Yes or rto Rican, etc.)	No-	14. Race - White,		can Indian, Black,
after de	by Fu	3 Widowed	4 Di	vorced if Yes, or Dat	Give Year	2 X No	1	Yes	2X No	specify:			Specify: I	Bla	ck
hours natur	ed be	15. Decedent's Ed		cify only high	nest grade co					n (Give kind o		16b.	Kind of Busi	ness/Ir	ndustry
336 thin 72 e. than edical	Completed	Elementary/Secondary 12th Gr			ollege (1-4 o	r 5+)	N/A					l N	I/A		
5-00 lled wi Hygier other		17. Father's Name	(First, Middle			- 4	21/ 11		18	3.Mother's Nar	ne (First, Middle				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Richard 19a. Informant's Na			rint)		I 10h Maili	na Addres	SE /Ctroot		r Rural Route N			Oleke	7ia Cada)
MD 2 shou alth and N 27 is no		Louis E			,	dad)	1				, Gwyr				· ·
re, I		20a. Method of Dis	position			20b. P	Place of Disportenatory or o	sition (Na	ame of ceme	etery,	Date	20c.	Location - C	ity or	Town, State
Baltimore, permit. Pages I an Department of Hea Important: If ite injury or other tr	1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Woodlawn Cemetery 11/09/11 Baltimore														
Bal permit Depar Impo		21. Signature of Fu	neral Service	Licensee	11).1	Vinn	²² 5	1658 40 i	eMedrenerg N. Fi	f ^{Fa} Bbrow ilton	n Jr.	Fun	eral	Но	me PA
Physician														Approximate Interval	
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		or condition resulting		Due to b.	(or as a con:	sequence of):								
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and	76	UNPENDED		d.	NDED										
60, ate be o	ğe di	IF FEMALE:		23c.	If yes, outco	me of pregn	ancy					23	d. Date of de	eliverv	
687 certific nding p	ian	23b. Was decedent past 12 months		11	Live birth Pregnant a	t time of dea	ath -	etal death		Ectopic preg	nancy		Month	Da	ay Year
cords, P.O. Box 68760, law requires that the death certificate be ex has been signed by the attending physician 2 should be detached for use as the burial.	Physician/Medic	1 Yes 2 N		known 9	Unknown		3 🗌 0	ther (Sp				Ì			2.5
that the ned by detach	b P	Part II. Other signif	ficant condit	ions contril	outing to dea	th but not re	sulting in the	underlyin	g cause giv	en in Part I.					ne cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Bed	-									24a. Wa				opsy findings available
e law r e has b ge 2 sh	Completed										aut per	opsy formed?	prio dea	or to co ath?	impletion of cause of
ision of Vital Rec Attending Physician: The I or death. After this certificate by the funeral director, page	မ်ို့ မြ	25. Was case referr	ed to medica							f Death (Chec		2 N	1	Yes	2 No
F Vit			2 No	Hospital	ı ınpatı		ER/Outpatien				ing Home 5		-		Scene
nding Pl th. r: After e funeral	<u>ë</u>	27. Manner of Death 1 Natural	n 5 Pend	ا ا	a. Date of Inj Month Day ct 27, 2011	ury Year)	28b. Time of 2210 hrs	Injury	28c. Injury	at Work? s 2 ✓ No	28d. Describ Subject sh		ury occurred		
ViSic or Atte fter dea birecto in by th	licat	2 Accident 3 Suicide		stigation 28	le. Place of l	njury - At hor	me, farm, stre	et, factor					and Number	or Rura	al Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification: To	4 V Homicide			Specify) Lo	cal Stree	t				or Town, 1200 Blk. B		Avenue, Ba	altimo	re, MD
	Medical			miner: On the	basis of exa	mination an					nd due to the ca I at the time, dat				
To the within To the comple	¥e	29b. Signature and		and m	anner stated				c. License r						h, Day, Year)
	1	1 X ac	lore	eur	1				O.C.M.	E.		Oct	ober 28, 2	2011	
		30. Name and addre						altimor	e Street	Raltimore	MD 21223				
Sta	ite	31. Date filed (Mont		ssistant IV		aminer ar's Signatu	11		e sireet,	illinore,	IVID 2 1223				
Registr		N	UV U 3	2011	Denew	62	. pa	Ker							

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Boettcher		epartment of Health and Menta Certificate of Death	Reg. No.	3508
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year October 16, 2011	3. Time of Death 0008 hrs
	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of I		1
Funeral	5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	Min	n _
Director	213-36-4605 1XM 2F Usual Residence of Decedent	70 Yrs.	7/18/1941 00	untry) MD
w any		. City, Town or Location		10d. Inside City Limits 1 Yes 2 X No
the Maryland a nr 28a-f show tified at once. Director	MD Anne Arundel 10e. Street and Number	Edgewater 10f. Zip Code	10g. Citizen of What Cou	ntry?
isth with the Maryland items 23a nr 28a-f sho ast be notified at once ineral Director	1615 Havre de Grace Dr.	21037	USA 144 Bass American	ican Indian, Black,
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked after than "natural", ar items 23a ar 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 X Married 12. Was Decedent Ever	If Yes, specify Cuban, Mexican, P		ican indian, black,
rs after c ural", u miner n	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:	Specify: Whind of work done 16b. Kind of Business/	
5-0036 ed within 72 hour stygene. other than "nature the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT us	se retired)	0
21215-0036 uld be filed within 7 Mental Hygiene. marked uther than c event, the Medica	12 17. Father's Name (First, Middle, Last)	Superintendent 18.Mother's	Trenching Name (First, Middle, Maiden Surname)	Company
d be file fental H warked revent, til	Earl H. Boettcher 19a. Informant's Name/Relationship (Type, Print)		ces Dove er or Rural Route Number, City or Town, State	. Zip Code)
MD 21 12 should th and Me 27 is ma umatic ev	Darlene Boettcher / Wife	1615 Havre de Grac	e Dr., Edgewater, MD	21037
Baltimore, MD permit. Pages I and 2 sho Department of Health and Important: If item 27 is injury or other traumati	20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City of 10/18/2011 Edgewate	
altim mit. Pag partment portant: ury or o	4 Donation 5 Other Specify: 21. Signature of Funeral Solvice Licensee	22. Name and Address of Facility	George P. Kalas Fune	ral Home
	23a. Part I. Enter the disease, or complications that caused the	2973 Solomons Is	sland Rd., Edgewater,	MD 21037 Approximate Interval
Physician IN edical Examiner	failure. List only one cause on each line.	rosclerotic Cardiovascular Disease		Between Onset and Death
Examiner	or condition resulting in death) Due to (or as a conseque	ence of):		
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ence of):		
_ 9	(Disease or injury that initiated events resulting in death) Last Due to (or as a conseque d.	ence of):		
e be execute be execute sysician and burial - tra	UNPENDED AMENDED			
3876 rtificate ing phy as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of the past 12 months? 23c. If yes, outcome of the past 12 months?	2 Fetal death 3 Ectopic p	23d. Date of deliver pregnancy Month	y Day Year
D. Box 6: the death ce by the attend sched for use	1 Yes 2 No 9 Unknown 9 Unknown	other (opecity)		()-10
ires that the signed by a lbe detach	Diabetes Mellitus, Chronic Obstructive Pulm		23e. Did tobacco use contribute to 1 Yes 2 No 3 Pro	
Records, The law requirer ficate has been sig, page 2 should be Completed			autopsy prior to	utopsy findings available completion of cause of
tal Reco		CO Disease of Death (C	performed? death? 1 ✓ Yes 2 No 1 ✓ Y	es 2 No
Vital Rechysician: The this certificate di director, page	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient	26.Place of Death (C 2 ✓ ER/Outpatient 3 DOA Other 1	Nursing Home 5 Residence 6 Other	er:
n of viding Ph. After t a funeral	27. Manner of Death 1 Natural 5 Pending	28b. Time of Injury 28c. Injury at Work?		
Division (spital or Attending nours after death. ners a Director. Af filled in by the fun Certification	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury	- At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or R or Town, State)	ural Route Number, City
Hospital Suncral ely filled	4 Homicide determined (Specify) 29a. Certifier 1 Certifying Physician: To the best of my kn	nowledge, death occurred at the time, date and plac	e, and due to the cause(s) and manner as sta	ited.
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: / completely filled in by the fi	one) 2 Medical Examiner:On the basis of examina and manner stated.	ation and/or investigation, in my opinion, death occurrence and 29c. License number	urred at the time, date and place, and due to t	he cause(s)
NA S	29b. Signature and title of certifier	O.C.M.E.	October 16, 201	
48	30. Name and address of person who completed cause of death	h (Item 23a) 900 W. Baltimore Street, Baltimore, M	ID 21223	
State	I 22 Putatora			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Item 25 per me. g921,11/01/2011dhb
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Health and Mental Hygiene
Certificate of Death

Reg. No. 2 | | 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:20P 2011 Marshall Albert Burgess, Jr. OCTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAINT JOSEPH MEDICAL CENTER TOWSON BALTIMORE . Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth Funeral Days July 30 1 X M 2 🗆 F Months Hours Year 1920 705-12-5394 91 Maryland **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits or 28a-f sho notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director Cockeysville MD **Baltimore** 1X Yes 2 No 10g. Cit. 10e Street and Number 10f. Zip Code ò Citizen of What Country? ms 23a or must be n Funeral 21030 300 International Circle Apt. 344 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed "natural" 3 X Widowed 4 Divorced Year or Dates Ith and Mental Hygiene. 27 is marked other than "natur r traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Transportation Traffic Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)
Ethel Carroll 17. Father's Name (First, Middle, Last) ပ္ Marshall Albert Burgess, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State 63 Wethersfield Dr., New Freedom, Pa 17349 Wayne C. Burgess - nephew permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadowridge Mem. 10/10/2011 Elkridge, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JJ Hartenstein Mortuary, 21. Signature of Funeral Service Licensee per DVR 24 N. Second St., New Freedom, PA 17349 Michael W. Murnane 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ACUTE RENAL FAILURE Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Examine CATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed inding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) CERTIFIE Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) ed by the attending detached for use as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed ral director, page 2 should be def 23e. Did tobacco use contribute to the cause of death? Completed by GASTROINTESTINAL BLEEDING 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? ACUTE MYOCARDIAL INFARCTION 24a. Was an autopsy 1 Yes Yes after death.

Director: After this certific in by the funeral director, Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 X Yes -2 X Ne Other: ည 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation To the Hospital or Atter within 24 hours after dea To the Funeral Director completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Number Practioner: To the set of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 Certifying Nu only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D69989 10.5.11. on who completed care of cleath (Item 23a) (Type, Print)
MALININ, N.D. 7601 OSLER DRIVE TOWSON, MD 21204 20 31. Date filed (Month, Day, Year, State NOV 0 1 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23ab per MD FCHD TM 10/19/11
State of Maryland / Department of Health and Mental Hygiene 35083 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month October Physician/ 2°011 12:55 AM MILDRED BROWN MARVA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex **Funeral** 1 □ M 2 🛛 F Year 1949 Hours (Month, Day eb. 19 Months Days West Virginia Feb. Director 216-50-8036 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland must be notified at Director 1 √2 Yes 2 □ No Walkersville MD Frederick 10g. Citizen of What Country? ö 10e. Street and Number 10f. Zip Code Funeral 23a USA 21793 109 Sandalwood Court ral", or items? Examiner mus 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event the Maries I. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed | 3 Divorced White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Mildred Genevieve Gageby Marvin John Lewis Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 7320 West Springbook Ct., Middletown, MD Becky Tobery/ Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10/14/11 4 ☐ Donation 5 ☐ Other (Specify) Martinsburg, WV Rosedale Cemetery Robert Arties Datiey & Son Funeral Homes, P.A. 21. Signatur of Funeral Prvice Licensee 1201 North Market Street, Frederick, MD 21701 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ poxia disease or condition Medical resulting in death) probable cardiac dyschythmia Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Metabo anding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical per Kalemia to the Hospital or Attending Physician: The law requires that the death certificate be twithin 24 hours after death.

To the Funeral Director: After this certificate has been completed filled in her than the twitter. IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 10 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, loeath occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ,0 [0]/1 address of person who completed cause of death (Item 23a) (Type, Print) 400 Frederik MP 21702 Bruntel W. 2+h 32. Registrar's Signature 31. Date filed (Month State Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760 lial or Attending Physician: The law requires that the clearly certificate he

_	For State Registrar 1. Decedent's Name (Firs	t Middle I as	State of Ma	aryland /	•	tificate of L				eg. No.	201	3508
sician/ /ledical aminer	Betty 4a. Facility Name (if not in	nstitution, give	Jane street and number)		Bast	4b. City, Town, or	Location of I	(Month Octobe	r 12	, 2011 ounty of Death Alle	8:20 P
eral ctor	5. Social Security Numbe 218-20-147	7 6. Se	x 7. Age	e (In yrs. last bi 85	irthday) Yrs.	If Under 1 Year Months Days	If Under 24		Date of Birth (Month, Day, 2 / 10 / 1	Year) 926	9. Birtl	hplace (State or Foreig intry) ryland
any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	MD	County	gany	10c. City, Tov		mberland						10d. Inside City Limits 1 X Yes 2 □ N
Funeral [nover S				10f, Zip Code	21502					USA
Examiner I	11. Marital Status 1 Never Married 2 3 Widowed 4		12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates.		- 1	Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🏋 No		1? (Specify Puerto Rica	yes or No- n, etc.)		I. Race - Amer Black, White pecify:	
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her traum	19a. Informant's Name/F Paul N. An	thony			704	g Address (Street Freeman		Richm	ond, \	JA 2	23221	
jury or ot	20a. Method of Disposition 1 X Burial 2 Cr 4 Donation 5 C	remation 3 🗆		cemei	tery, crem Mem	sition (Name of natory or other plac orial Ce	metery		6/20	1 (and, MD
any in	21. Signature of Funeral	Cloday	300		40	04 Decati	ır Stre	eet,	Cumber	land		Home, P.A 21502
ian/ lical liner	Immediate Cause (Final disease or condition resulting in death)	ure. List only or	e cause on each line	TE N	175	20 (-(4v0						Approximate Interval Between Onset and Death
e burial-transit	Sequentially list condition if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last		Due to (or as a Due to (or as a d.									
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uld be deta	Part II. Other significant	conditions co	intributing to death b	ut not resulting	g in the u	nderlying cause gi	ven in Part I.				_	the cause of death?
page 2 should be Completed									24a. Was a autops perform 1 Yes	med?	prior to death?	topsy findings available completion of cause of
Be (25. Was case referred to examiner?		Hospital:			Oth	lace of Death					
completed filled in by the funeral director, page 2 s Medical Certificate: To Be Comp	2 Accident	Pending Investigation	28a. Date of inju (Month, Day		Outpatier Time of injury	t 3 □ DOA 28c. Injur work	4 ∐ Nurs y at	28d.	5 XReside Describe ho		Other (Spec	ify)
led in by th		Could not be determined	28e. Place of Injubul		farm, stre	eet, factory, office		28f.	Location (St City or Town		Number or Rui	ral Route Number,
npleted filled	(Check 2 Nonly one) 3 C	Medical Exami Certifying Nurs	ician: To the best of ner: On the basis of e e Practioner: To the	xamination and	d/or invest	igation, in my opini leath occurred at th	on, death occi ne time, date a	urred at the	time, date an	d place, a cause(s) a	and due to the o and manner as	cause(s) and manner sta stated.
Ö	29b. Signature and title of		mc mc	,		29c. Licens	e number 33417				signed (Month tober	13, 2011
8	30. Name and address of James		ompleted cause of d	eath (Item 23a 1068 Na	atio	rint) nal Hight	way, La	aVale	, MD	2150)2	
State	31. Date filed (Month, Day	y, Year)		ar's Signature	,	Nest.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DENNIS FRANKLIN BAKER 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** Country)
St. Virginia 1 ▼ M 2 □ F Hours 02/17/1937 74 **Director** 234-56-5298 West Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director ıms 23a or 28a-f sh r must be notified a WV Ridgeley 1 Yes 2 No Mineral 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26753 U.S.A. Route 4, Box 86 items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 【 No If Yes, Give Year or Dates. 14. Race - American Indian. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten Examiner r Black, White, etc. þ 1 Never Married 2 K Married 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after Specify: White 1 ☐ Yes 2 X No Specify. "natural" Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than in traumatic event, the Me than Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Robert Baker Evelyn Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Eleanor Baker / Wife Route 4, Box 86, Ridgeley, WV 26753 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State of 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State = 6 Department or Important: If any injury or once, Fort Ashby Cemetery 10/07/2011 Fort Ashby, WV 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Upchurch Funeral Home, P.O. Box 1260, Fort Ashby, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line val Between Immediate Cause (Final d Death Myocardia Physician/ hour disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conseque nce of) -transit and that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-tra resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Emphysema 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perfor death? 2 No Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner's Other: 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pendina Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year)

Registrar

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dame and address of person who complete

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31. Date filed (Month, Day, Year)

Livengood

cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 0218 M 10 HNEL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ANNE ARUNDEL EDGEWATER 442 MAGNOLIA DRIVE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Security Numbe **Funeral** 1 DM 2 DF (Month, Day, Year) 09/06/1951 WEST VIRGINIA Director 220-56-3957 60 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🏋 Yes 2 □ No MARYLAND ANNE ARUNDEL **EDGEWATER** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral ANNE ARUNDEL 442 MAGNOLIA DRIVE 21037 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 ▼ Never Married 2 ☐ Married Yes 2 XNo ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of work life. DO NOT use retired) CUSTOMER 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) SERVICE REPRESENTATIVE COMMUNICATION Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည GLORIA SINER JOHN J. BURNETTE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 442 MAGNOLIA DRIVE EDGEWATER, MD 21037 CHRISTY WITT/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place)
CHESAPEAKE CREMATION 10/20/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State STEVENVILLE, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility LASTING TRIBUTES BY FELLOW IELFENBEIN & NEWNAM CREMATION & FUNERAL CARREL B14 BESTGATE ROAD ANNAPOLIS, MD 21401 21. Signature of Faneral Service CARE P.A. BESTGATE ROAD ANNAPOLIS or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Dan 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death signed by the at id be detached fo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 4 Unknown Division of Vital Records, 1 Yes 2 No 3 Probably peen (Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performe Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate 24 hours after death.

Funeral Director: After this certific eted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: iniury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 3 the only one within To the 29b. Signature and title of certific

State Registrar gistrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Day Physician/ Month Louise E. Blades 2011 5:02 Oct Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Talbot The Pines Easton Genesis HealthCare -Birthpia Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year 6-23-1924 1 □ M 2 🗓 F 87 Director 216-16-7180 Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Sant: If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County Director 1 Yes 2 No Talbot Easton MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21601 USA 610 Dutchmans Lane Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black White, etc. Completed by 1 Never Married 2 X Married 1 Yes Louise Blades Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ Emma Fluharty Floyd W. Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8524 Mullet Branch Rd Easton MD 21601 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Peggy Swann (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 10-17-2011 Easton, MD Springhill Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility ellows, Helfenbein & Newnam Funeral Home P.A. 00 S. Harrison St Easton MD 21601 LERGY Approximate Interval Between O set and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

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a. provious cerebrovasuler accodent Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequince Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine ua are Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last years Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Other (specify) signed by the and be detached for Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed' 1 🗆 Yes 2 🗆 No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 Tes After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 Natural Certificate: injury 5 Pending 24 hours after death. Funeral Director: Af Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

6 State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

610 Registrar's Sign

29b. Signature and title of cer-

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar FH, 7CHD, 10 | 14 | η Pha Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 09: 15 AM ROSA BAILEY 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DORCHESTER CAMBRIDGE CHESAPEA KE 1400 DS NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 💢 Hours 9 **Director** Usual Residence of Decedent 28a-f shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho. 10d. Inside City Limits 10a. State 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? SA Funeral 21643 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗙 No Specify. If Yes, Give 3 XWidowed 4 ☐ Divorced Completed BLACK Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Pickle Elementary/Seconday (0-12) College (1-4 or 5+) ine Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann niece 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other plan Burial 2 Cremation 3 Removal from State Federalsburg emetery Donation 5 Other (Specify) Main Sign June neral Service Licenses HU-lock, MD 21643 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death FAILURE Immediate Cause (Final CONGESTIVE Pnysician/ disease or condition resulting in death) HEART Medical Due to (or as a consequence of Examiner DISEASE DNE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown been signed by the should be detached 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 s autopsy performed? Yes 2 No 1 Yes 2 No rs after death. al Director. After this certificate מאלים in by the funeral director, אי Be 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: 2 **N** No ျှ 1 Tes Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 \square Yes 2 🗌 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Vithin 24 hours are To the Funeral Dir Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MD D69234 2011 10-13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613 CAMBRIDGE ERRABOLU MARYLAND STREET JEEVAN

DHMH 17 Rev 7/2009

State Registrar . Registrar's Signa

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		For State Registrar	State	of Mary	land /		rtment of H tificate of D		na ivi	ептаг ну		No. 201	B-dark-stated	35089
Physicia		1. Decedent's Name (First, Middle, Charles	Last) Vayne	Bur	rell					2. Date of De		Day 2011	ar	3. Time of Death 8:00 p M
Medic Examin		4a. Facility Name (if not institution, on Oakland Nursing	give street and nu	^{nber)} Cente	r		4b. City, Town, or Oakla	nd				4c. County of E	ett	
Funeral Director		5. Social Security Number 212-24-0535 Usual Residence of Decedent	6. Sex 1 ★ M 2 ☐ F	7. Age (In) 83	rs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. Min.	8. Date of Bir 07 18	th ay, Yea	928	Birthpi Count	ace (State or Foreign WV
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County WV Presto	on		. City, Tov									0d. Inside City Limits 1 ☐ Yes 2 🕅 No
n with the	neral [10e. Street and Number 2115 Brookside F	Road				10f. Zip Code 26705					Citizen of What	Coun	ry?
rs after death Iral", or item Examiner n	by	11. Marital Status1 ☐ Never Married 2 ☑ Marrie3 ☐ Widowed 4 ☐ Divorced	12. Was Dec Armed F ed 1 X Yes If Yes, G Year or D	orces? ve No		If	/as Decedent of His Yes, specify Cubar ☐ Yes 2 X No	n, Mexican, P	n? (Spec Puerto F	cify Yes or No- Rican, etc.)		14. Race - A Black, V Specify:	/hite, e	
ithin 72 hou ene. • than "natu the Medical	Be Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12)	st grade completed	1-4 or 5+)	16	(Give k	ent's Usual Occupa ind of work done do NOT use retired)	uring most of	f workir	ng	16b	bui.		
id be filed w Mental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, La Kepton Brite Bur					carpente	18. Mother's		(First, Middle		len Surname)		
id 2 shou salth and n 27 is m er traum:		19a. Informant's Name/Relationshi Virginia D. Burr		2			g Address (Street a Brooksid						, Zip C	ode)
t. Page 1 ar rtment of He rtant: If iten rjury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 0ak Grove Cemetery 21. Signature of Funeral Service License 22. Name and Address of Facility David A. Burdock Fu												, WV
permi Depar Impol any ir		1 CACT	Trendly			2	l N 2nd s	t, Oal	k1ar	nd, MD	21.		ile I	al nome ra
Physician/ Medical Examiner		23a. Part 1 Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a		Se	ver	the mode of dying			N.		expa	+	Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	C	o (or as a con										
(e) Hi (c)	_	resulting in death) Last	Due to	(or as a cor	sequence	e of):			_				1	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	by Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e Birth 2 🗀 gnant at time	Fetal dea		Ectopic pregnance Other (specify)	у				23d. Date o		ery Day Year
quires that then the signed by sould be deta	ted by Pl	Part II. Other significant condition	ns contributing to	death but no	ot resulting	g in the u	nderlying cause giv	en in Part I.						e cause of death?
in: The law re ificate has be or, page 2 sh	e Completed	25. Was case referred to medical	C	Vind.	W V	ren	ten d	Jere Gere	Check	1 Ves	opsy formed	prio dea	r to coi th?	osy findings available mpletion of cause of
ing Physicia fter this cert ineral direct	ate: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Dat	Inpatient e of injury nth, Day, Yea	28b	Outpatien Time of injury	t 3 DOA Othe	4 Nurs	sing Ho	me 5 Res		e 6 Other (S	Specify)
al or Attendi s after death I Director: A d in by the fi	Certificate:	2 Accident Investig. 3 Suicide 6 Could n 4 Homicide determin	ation not be 28e. Place	e of Injury - ding, etc. (Sp		farm, stre	M 1 L	Yes 2□N	\rightarrow	28f. Location City or To		t and Number o tate)	r Rural	Route Number,
the Hospit: hin 24 hours the Funeral upleted fille.	Medical	(Check 2 Medical Exonly one) 3 Certifying	xaminer: On the ba	asis of exami	nation and	/or invest	leath occurred at the	n, death occu e time, date a	urred at	the time, date	and p	lace, and due to use(s) and mann	the car	use(s) and manner state ated.
og P wit	A	29b. Signature and title of certifier	\sim		//har- 02 :	\/T		s number	3		29d.	Date signed (A	onth, i	Day, Year)
3+1		30. Name and address of person w						St, S	Suit	te II,	0a	kland,	MD	21550

State Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

OCT 2 0 2011

Across Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Della Jean 11:16 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MD Oakland GARCETT Garrett County Memorial Hospital 5. Social Security Number 8. Date of Birth (Month, Day, Year) 09 14 1923 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 1 🗆 M 2 🗷 F Months Director L49-16-0790 MD Usual Residence of Decedent 28a-f show 10b. County Examiner must be notified at 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 X Yes 2 No MD Garrett 0akland 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? 201 E. Mason St, Apt. 12 21550 USA Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Completed 3 Nidowed 4 Divorced White ed other than "natu event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) is marked other clerk retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Thomas W. Savage Della A. Rodeheaver 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 6 Kalten Road, Westminister, MD 21158 Larry Ward-son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oakland_Cemetery 10/19/2011 Oakland, MD 21550 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line. or complications that caused the death. Do not enter the mode of dying, such Approximate
Interval Between
Paset and Death
LWEEK Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence **Examiner** Sequentially list conditions, Physician/Medical Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, the Hospital or Attending Physician: The law requires cate has been signated by page 2 should by Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dii Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 1 Natural (Month, Day, Year) iniury 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Lecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 10,14,11. D23979

Registrar
DHMH 17 Rev 7/2009

State

30. Name and addre

31. Date filed (Month, Day, Year)

Robert A. Goralski, M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 3509 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death Examiner Washindon Health Tour Caro Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Hours Min Oct. I. 1952 Country) C 59 578-70-5884 Director Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Washington Hagers town 1 Yes 2 X No Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A 21742 Funeral 14014 Marsh Pike 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify:Black "natural", Completed 3 Widowed 4 Divorced and Mental Hygiene.
is marked other than "natur
aumatic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Laborer 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be to Department of Health and Mental Important: If item 27 is many injury or other ပ UnKnown UnKnown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
122 N. Potomac St.P.O. Box 1419 Hagers town, Md. 21741 Carol Suker (Guardian) 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Oct. 25. cemetery, crematory or other place)
Smithsburg Crematory 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Md. 12525 Bradbury Ave. Signature of Funeral Service Licensee 22. Name and Address of Facility M01414 J.L. Davis Funeral Home Smithsburg, Md. 21783 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (ou s a consequence of) **Examiner** 10 Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) -transit Due to (or as a consequence of) burialattending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has ospital or Attending Physician: The la hours after death.
uneral Director; After this certificate ha ed filled in by the funeral director, page £ performed? Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: _2.2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d Date signed (Month, Day, Year 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State Registrar 14014 MKISh

Pike Hagerslown

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 05, 2011 Year Physician/ Leonard E. Cutter Sr. 11:03 AM M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Western MD Regional Medical Center Cumberland 5. Social Security Number If Under 24 Hrs Date of Birth 9. Birthplace (State or Foreign If Under 1 Year **Funeral** Age (In yrs. last birthday) Days Hours Month Day, 11, 1926 Maryland 216-22-5559 85 Director Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Rant: If item 27 is marked other than "natural", or items 23a or 28a-f sho land rother traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Allegany Frostburg 1 Yes 2 No Maryland 10e. Street and Number 19908 Adams Mill Road, S.W. 10f. Zip Code 10g. Citizen of What Country? Funeral 21532-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 🗌 Widowed 4 🗌 Divorced If Yes, Give Year or Dates. WWI 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Gasoline Station Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Bessie Mae Plummer William Henry Cutter, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 21532-Maryland Mildred Cutter 19908 Adams Mill Road, S.W Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Burial 2 Cremation 3 Removal from State maryland Veteran's Cemetery Flintstone Maryland October 07, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ GASTROINTESTINAL disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day 9 Unknown signed by Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DETIC STENOSIS 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should ULMONARY FIBROSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy yes 2 No certificate ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) funeral director, Hospita Other: မှ 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending after death. Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 31875 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Robert

31. Date filed (Month, Day, Year)

Welik

barke

2502 Willowbrook Rd.

32. Registrar's Signature

21502

Cumberland MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Alexander Collins, Sr. William 2011 2340 P M October Medical 4c. County of Death Allegany 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cumberland **Examiner** Western MD Regional Medical Center 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth **Funeral** 1 X M 2 □ F (Month, Day, Year) 04/28/1942 69 **Director** 216-40-3093 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 USA Funeral 21502 items 23a 13212 Judy Lane, NE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🌠 No If Yes, Give Black, White, etc. ō ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Divorced 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Car Dealership Owner President / Be 18. Mother's Name (First, Middle, Maiden Surname)
Trene Miller 17. Father's Name (First, Middle, Last) ည Vivian Collins William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 13212 Judy Lane, NE, Cumberland, MD 21502 Ina E. Collins / Wife 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 🗓 Burial 2 🗆 Cremation 3 🗀 Removal from State Sunset Memorial Park 10/15/2011 Cumberland, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Adams Family Funeral Nome, 21. Signature of Funeral Service 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line BRUNCHOGENIC Immediate Cause (Final Physician MA Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes ∠ ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ PNEUMONI 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗷 No 은 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State,

24 hours after deat Funeral Director: To the within 2

31. Date file of thouth, Pay Year 11

nd tille of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robustiano J. Barrera, Jr., M.D.,

> 32. Registrar's Signature saute

State

Registrar

Medical

29a. Certifier

29b. Signature

(Check

only one

X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0014865

200 Glenn Street, Cumberland, MD

29c. License number

29d. Date signed (Month, Day, Year)

October 13, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35094 State of Maryland / Department of Health and Mental Hygiene? Amended item = State Registrar #26, per physician, 10/20/10 ertificate of Death E.T., WCHD Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:03 M Claypool Charlotte L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice at Salisburg Wicomico Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Min. Hours 1 □ M 2X F 1 1^M974, 94, 950 220-46-4634 60 **Director** MD Usual Residence of Decedent 28a-f show 10d. Inside City Limits important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Berlin MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21811 8428 Stephen Decatur Hwy. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 K Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. white Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Frontier Town rounds Crew Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ည Charlotte Whitkee Floyd Wadsworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8428 Stephen Decatur Hwy., Berlin, MD 21811 Department of Health Important: If item 27 Jeff Claypool / husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 D Burial 2 Carcemation 3 D Removal from State 10/18/11 State Crem. Millsboro, 4 Donation 5 Other (Specify) al Service Licens 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causeron ach line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exam Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician and be detached for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregpant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 mos Pregnant at time of death 2 No Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed? certificate 2 No 2 🗓 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No မ 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury Matural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print) TEAN SHILEDRI State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Day 10 2 Tal 1 Physician/ 1416 M Marvis V. Cook Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2**X**) F Days Hours Maryland 214-72-1255 53 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 404 C Captains Circle 21401 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. "natural", or 1X Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working United States 1 and 2 should be filed within 72 of Health and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) O Naval Academy Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Cook Sr Elizabeth Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Padrone Savoy Sr(Son) 404 C Captains Circle Annapolis, Md. 21401 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20H Place of DSpseing (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 1 X Burial 2 Cremation 3 Removal from State Memorial Gardens 10-17-11 Annapolis, Md. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Witharne are described Facility Sons Mortuary, P.A. 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) anding physician use as the burial Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 morths?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy has To the Hospital or Attending Physician; The within 24 hours after death.
To the Funeral Director; After this certificate it completed filled in by the funeral director, page Yes 2 T 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) |₽ 1 🗌 Yes 2 100 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 🗌 29b. Signature and title of certifier 29d Date signed (Month, Day, Year, 44007048 alto o.d. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gonle 31. Date filed (Month, Day

State Registrar 32. Fegistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State	State of Maryland / Department		2011 351191			
			Registrar 1. Decedent's Name (First, Middle, La.		rtificate of Death	Reg. No	3. Time of Death		
	Physicia Medic		WILLIAM PA	ARK CUTHBERTSO	w JR	Month 10 Day	27 201 13:48 PM		
	Examin	er	4a. Facility Name (if not institution, give 8913 Hi GH S	estreet and number)	4b. City, Town, or Location of Death		ALLEGA NY		
I	Funeral Director		5. Social Security Number 2,15-20-6223 6. S	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	g. Birthplace (State or Foreign Country)		
	d t t	L	Usual Residence of Decedent 10a. State 10b. County	10c, City, Town or Lo	vaction		10d. Inside City Limits		
	//anylan/ 8a-f sh tified a	Funeral Director	MD ALLEG	BARTON	, de la constant de l		1 Mary 2 □ No		
	th the N 3a or 2 t be no	ral Di	10e. Street and Number	?	10f. Zip Code	10g. Cit	tizen of What Country?		
	ems 2	nue	8913 HIGH =	12. Was Decedent Ever in U.S. 13.1	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian,		
36	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 X Yes 2 No 6/17/46	If Yes, specify Cuban, Mexican, Puerton 1 Yes 2 No Specify:		Black, White, etc. Specify: Wh:+e		
9-6	hours natura lical E	lete	15. Decedent's E		dent's Usual Occupation	16b. K	ind of Business Industry		
21215-0036	within 72 giene. er than " , the Mec	Completed by	(Specify only highest gr Elementary/Seconday (0-12)		kind of work done during most of wor OO NOT use retired) In Spring field tire		borer		
	led within Hygiene. other tha	Be C	17. Father's Name (First, Middle, Last)	Nell		me (First, Middle, Maiden			
Maryland	ould be fil d Mental marked matic ev	은	William Park	Cuthbertson Sr.	: Jan	e Dunn			
Mar	and and is n		19a. Informant's Name/Relationship (1		ing Address (Street and Number or Ru 5/2 New Georges	ral Route Number, City or Creek . RL SW:	Town, State, Zip Code) Frest burg Md 21532		
			20a. Method of Disposition	20b. Place of Dispo	osition (Name of	Date of 20c. L	ocation - City or Town, State		
Baltimore,	Page ment o tant: If ury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		matory or other place)	1/2011 Bar	ton, md.		
Balt	permit. Page Department of Important; If any injury or once.	l li	21. Signature of Funeral Service Licen	me 11 Church	St. Westergant. md21562				
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only of	Approximate Interval Between					
	nysician/ Medical	1	Immediate Cause (Final disease or condition resulting in death)	a CHRONIC	Isettemic !	HEART b	Onset and Death		
	Examiner			Due to (or as a consequence of):					
	p is	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of).					
	xecute n and al-trans		Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence of):					
09	ate be executed oblysician and the burial-transit	dical		■ d					
687	ertifica Iding p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delivery		
P.O. Box 687	hat the death certifics ed by the attending p detached for use as t	Physician/Me	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 Fetal death 3	Control Ectopic pregnancy Other (specify)		Month Day Year		
0	at the d		9 Unknown Part II. Other significant conditions of	contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco u	use contribute to the cause of death?		
IS, P	w requires that s been signed t should be det	ed by	HYPERTER	らるう		1 🗆 Yes 2	No 3 Probably 4 Unknown		
corc	aw req as bee 2 shou	Completed	HYDOTHYR	oldism		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of		
æ	siclan: The law scrifticate has be lirector, page 2 s		, ,			performed?	death? o 1 🗆 Yes 2 🗆 No		
/ital	s certifi	To Be	25. Was case referred to medical examiner? 124 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Che	ck only one) Home 5 Residence 6	Other (Specify)		
of	ng Phys ter this ineral di		27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of injury (Month, Day, Year) 28b. Time of injury injury		28d. Describe how injur			
sion	I or Attending I after death. Director: After I in by the funer	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not be		M 1 ☐ Yes 2 ☐ No	206 Leastien /Street on	d Number or Rural Route Number,		
Division of Vital Records,			4 Homicide determined	building, etc. (Specify)	eet, factory, office	City or Town, State			
	ne Hospita n 24 hours ne Funeral pleted fillec	Medical	(Check 2 Medical Exam	vsician: To the best of my knowledge, death on the basis of examination and/or investors Practioner: To the best of my knowledge, or	stigation, in my opinion, death occurred	at the time, date and place	e, and due to the cause(s) and manner stated.		
	To the I within 2 To the I comple		29b. Signature and title of cen fier	-1.1000-	29c. License number		te signed (Month, Day, Year)		
			30. Name and address of nerson who	completed cause of death (Item 23a) (Type, F	17 0/875	0 00	10300 CF 2011		
		2	PR. ROBERT A.	. WELIK, 12502	WILLOW BROOK F	COAD, Cum	TOBER 28 2011 BERLAND, MD 21502		
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	arked	•	•		

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 15^{pay} 201T 7:45 P M John Low Carnochan, Jr. October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Buckingham's Choice Adamstown 9. Birthplace (State or Foreign 8. Date of Birth 0CL 19, 1918 Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 1 🛣 M 2 🗆 F Months Davs Hours Mary Tand 92 Director 219-01-9550 Usual Residence of Decedent 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Frederick Adamstown 1 Yes 2 X No Maryland | 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? ö United States Funeral items 23a 21710 3200 Baker Circle, I-109 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc. Il Hygiene. other than "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 72 hours after Specify: White 1 ☐ Yes 2 No Specify. rres, Give Year or Dates. 1941–64 Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Public Education Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental His marked of ge 1 and 2 should be fil it of Health and Mental : If item 27 is marked Susan Long John Low Carnochan, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3200 Baker Circle, I-109, Adamstown, MD 21710 Emily Carnochan / Wife 0ct. 2<u>011</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Tate 8. permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 ☐ Burial 2 ☼ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Frederick, Maryland Resthaven Crematory Signature of Femeral Service Licensee Skkot Cody P.A. ResthavenesFundival Services, 9501 Catoctin Mountain Hwy. Frederick, MD 21701 Part — Ent., the disc ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest ships or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm te /ause // inal disease or condition resulting in de th) Physician/ Athero scleration Vascular Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Ener U company Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burial-1 ending physician use as the burial Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 Pregnant 9 Unknown Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown is been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy death? performed' 1 Yes 2 No this certificate Yes 2 X No 25. Was case referred to medical Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျ 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending Pl 124 hours after death. e Funeral Director: After th 28c. Injury at Certificate: 28d Describe how injury occurred work?
1 Yes 2 No iniury 1 X Natural 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) -17-2011 .mo D0058726

Registrar

14+1

State

Vette

31. Date filed (Month

Ventrie

Ct.

Mersville

21773

MO

3000-D

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

Warren

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Eva Mae Coddington Month 10 4:00 p M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Oakland Nursing & Rehab Center 0akland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours Min (Month, Day, Country 1 M 2 KF Months Yrs Director 233-68-1652 66 Usual Residence of Decedent r 28a-f show notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Mt. Lake Park Garrett 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or Funeral 614 I Street 21550 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian Examiner Black, White, etc. ō p 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: Specify: "natural", 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) 721 Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 homemaker own home auth and Mental Hy.
Item 27 is marked other
or other traumatic ever Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Noah Miller Retta Tremblev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 614 I Street, Mt. Lake Park, MD 21550 Larry Coddington-husband 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗷 Burial 2 🗌 Cremation 3 🔲 Removal from State Garrett Co. Mem Gardens 10/20/2011 Oakland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility David A. Burdock Funeral Home PA N 2nd St, Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immediate Cause (Final Physician/ Myocardial Infarction disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multi-Infarct Dementia 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an Type II Diabetes has autopsy performed? Yes 2 X No page 1 Yes 2 No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Hospital Other: 2. Z No 1 Tyes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Z Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Z Natural 5 Pending death. Accident Investigation within 24 hours after death

To the Funeral Director.,
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifie

Daniel Miller, 69 Wolf Acres Drive, Oakland, MD 21550

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registra s Signature

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

H26154

29d. Date signed (Month, Day, Year)

10/18/2011

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep State of Maryland / Dep Registrar Ce	ertificate of E			iene 20	35099
	Physicia	an/	1. Decedent's Name (First, Middle, Last) Elizabeth L. Dunleavy	h Day Year	3. Time of Death			
1	Medic Examin	cal	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or	Location of Death	Oct	11 201 4c. County of Dea	
			Genesis HealthCare - The Pines		aston I if Under 24 Hrs.		Talb	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 212-16-7877 7. Age (In yrs. last birthday) 95 Yrs.	Months Days	Hours Min.	8. Date of Birth 2-6-191	Year) C	rthplace (State or Foreign ountry) MD
	nd how at	Ž	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Literature	ocation				10d. Inside City Limits
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	th the 3a or 2	al Di	10e. Street and Number	10f. Zip Code		1	0g. Citizen of What C	ountry?
	eath wi	Funeral	29 Mt. Pleasand Ave. 11. Marital Status 12. Was Decedent Ever in U.S. 13.	2160 Was Decedent of His	ispanic Origin? (Spe	cify Yes or No-	USA 14. Race - Am	
36	after de l", or if xamine	Š	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Yes, Give	If Yes, specify Cubar 1 ☐ Yes 2 🌠 No		Hican, etc.)	Black, Whi	·
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Elizabet Baltimore,			20a Method of Disposition 20b Place of Disp	osition (Name of ematory or other plac	re)	Date	20c. Location - City o	r Town, State
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying	g, such as cardiac o	or respiratory arre	st,	Approximate Interval Between Onset and Death
	hysician/ Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	DIVATO	y tail	uve		4 days
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_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Ot the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve	occured at the time,	, date and place, an on, death occurred at	d due to the caus	se(s) and manner as s d place, and due to the	tated. e cause(s) and manner stated.
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	u		30. Name and address of person who completed cause of death (Item 23a) (Type,	D.A. D.	o Dutchm	on's La	NE FACT	on MD 21601
v.	Sta	te	31. Date filed (Month, Daly, Year) OCT 1 2 2011	hard .	C DOLOTH.	UTV2 NO	C P-131	7

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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9		Stat		31. Date filed (Mont	th, Day, Year)	32. Registr	ar's Signat	ture &	be d	, +							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANE ElizoBett October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death MERTIS Medical WOSHINGTON HAGRES BOWN If Under Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday 8. Date of Birth 1 M 2 V F Hours Sept. 18 Director Maryland 92 T919 214-09-6843 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f slany injury or other traumatic event, the Medical Examiner must be notified; Washington Md. Hagerstown 1 🗆 Yes 2 🗔 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20460 Jefferson Blvd. U.S.A 21742 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ₩ Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Kirby Dofflemyer Clara Ridenour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebekah Brown (Daughter) 11153 White Hall Rd. Smithsburg, Md. 21783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct. Smithsburg Crematory Smithsburg, Md. . Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. æ M01414 J.L. Davis Funeral Home Smithsburg, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Pulseloss disease or condition resulting in death) Medical Due to for as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine burial-transit and that initiated events resulting in death) Last the attending physician hed for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: signed by the attending d be detached for use yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Year 1 ☐ Yes ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has hare the force of the force autopsy performe 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes 2 No Other: ြု 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? Accident Investigation 2 🗌 No 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 17, 2011 Fernando Echeverria 12:10 p M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 100 Park Place Upper Marlboro Prince George's Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 926 XX M 2 G F Feb. 2 Months Davs Colombia Director 499-46-3454 85 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 10d. Inside City Limits 1 Yes XX No Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20774 U.S.A. 100 Park Place permit. Page 1 and 2 should be filed within 72 hours after death \text{Department of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

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If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married XX Married Baltimore, Maryland 21215-0036 Yes 2 No Specify: 3 Divorced 4 Divorced Hispanic 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Practice Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Margarita Burgos Dario Echeverria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Park Place, Upper Marlboro, MD 20774 Eloise Echeverria- Wife 20a. Method of Disposition

1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Maryland National 4 ☐ Donation 5 ☐ Other (Specify) <u>Maryland</u> 21. Signature of Funeral 6 22. Name and Address of Facility 6512 NW Crain Hwy., 20715 Bowie, MD 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failule. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 6 Months Ph_sician/ Metastatic Kidney Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Be Completed by Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Year 9 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsv performed? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 \(\sum \) Nursing Home \(\frac{\frexi\fir\f{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\frac{\ 1 🗌 Yes ဂ 2X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatur 29d. Date signed (Month, Day, Year) D08754 October 18, 2011

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month

7525 Greenway Ctr. Dr., #205, Greenbelt, MD 20770

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 29d per med cert G921 11/21/11 dk

State of Maryland 7 Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Les 12:500 Medical or Location of Death 4c. County of Death give street and nun **Examiner** 9. Birthplace (State or Foreign 1 Year If Under 24'Hrs 8. Date of Birth Age (In vrs. last birthday) If Under **Funeral** (Month, Day, Year) Min Country) 214-40-9877 Director 1 M 2 X F 71 06/05/1940 VA 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🗶 No MD Anne Arundel Shady Side 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 847 Broadwater Road 20733 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after death 12, Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify. Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Federal Govt. Adminatrative Assitant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jeanne Munnikhuysen Kenneth Rogers Nieman alth and N 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 629 Shady Side, MD 20764 Terri Witt (sister) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Woodfield Cemetery 10/17/2011 Galesville, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home Galesville Rd. Galesville, MD 20765 905 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Va Medical Due to (or as a consequence Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last signed by the attending physician d be detached for العم عم للم Physician/Medical death certificate be ₩ < 10. Box 68760 Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Month Day Year Pregnant at time of death 5 Other (specify) Yes g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes completely filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 N Hospital or Attending Physician: 7
 24 hours after death.
 Funeral Director: After this certifica Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 X Natural injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined. Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) £5-000 October 12, 2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) e St. Baltimore MD 21287 SOU 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

OCT 18

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Physicia		Registrar 1. Decedent's Name Donald	e (First, Middle, L				imodio oi =		2. Date of Dea Month		2011	3. Time of Death
Medic Examine		, ,	, 0	ve street and number)	1 Cent	ter	4b. City, Town, or Cumber			4c. Co	unty of Death Allega	any
Funeral Director		5. Social Security No. 212–24–10		Sex 1 M 2 □ F	ge (In yrs. Ia 84	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	1927		hplace (State or Foreign untry) WV
yland if show ed at	ctor	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits 1 Yes 2 □ No
ne Mar or 28a- notifi	Dire	MD 10e. Street and Nun	Garret	t	Mt.	Lake	Park 10f. Zip Code			10a. Citizen	of What Co	
with the s 23a c ust be	Funeral Director	712 K St					21550			0	USA	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Marr 3 Widowed		12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.	Ever in U.S	i. 13. \	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 🌠 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		Race - Amer Black, White Cify Whit	e, etc.
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Page nent o ant: If ury or			☐ Cremation 3 5 ☐ Other (Spe	Removal from State ecify)		r. Co.	matory or other place Mem. Gar	dens 10/			kland,	
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40 2 % 0	_	23a. Part 1. Enter t	the disease, or co	omplications that cause	ed the death							Approximate
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Medical Examiner		resulting in death)	4	Due to (or as					<u>-ii</u>	-		
	er	Sequentially list co	onditions,	b. ————————————————————————————————————	a consequ	rence of):						
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 1 ☐ Yes 2 [9 ☐ Unknown	months? ☐ No	23c. If yes, outcome 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of d	I death 3	☐ Ectopic pregnanc☐ Other (specify)	у		230	d. Date of de Month	livery Day Year
at the ed by t detach	/ Ph			s contributing to death	but not res	ulting in the u	underlying cause giv	ren in Part I.	23e. Did to	obacco use	contribute to	the cause of death?
luires t an sign uld be	ed b								1 🗆	Yes 2	No 3□P	robably 4 🗆 Unknown
The law rec ate has bee page 2 sho	Somplet								24a. Was autor perfo 1 \(\sum \) Yes		prior to death?	topsy findings available completion of cause of
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nding Phys Ith. : After this funeral di	cate: To	1 ☐ Yes 2 27. Manner of Deat 1 ☐ Natural 2 ☐ Accident	h 5 Pending Investiga	28a. Date of in (Month, D	jury	ER/Outpatie 28b. Time o injury	f 28c. Injury	4 □ Nursing F at	28d. Describe h			ify)
al or Atter s after des il Director ed in by the	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	t be 28e. Place of Ir	njury - At ho tc. (Specify		reet, factory, office		28f. Location (S City or Tow		umber or Ru	ral Route Number,
he Hospii in 24 hour he Funers pleted filk	Medical	(Check 2	Medical Exa	hysician: To the best of aminer: On the basis of lurse Practioner: To the	examination	and/or inves	stigation, in my opinio	on, death occurred	at the time, date a	and place, an	d due to the	cause(s) and manner stated.
Tot with Tot	1	29b. Signature and	title of certifier	ido Pa	ell	en	29c. License	634 (62	29d. Date s	igned (Mont	h, Day, Year)
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ John Flaherty Francis 2011 18:00 October Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Montgomery Montgomery General Hospital 01ney If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours 028-22-1988 81 1 🔀 M 2 🗆 F **Director** Aug. 19 1930 Massachusetts Usual Residence of Dec 28a-f show 10d. Inside City Limits an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director Montgomery 01nev 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20832 19628 Islander Street filed within 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ☐ Yes 2 🗷 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) 12 Pharmacy Department of Health and Mental Hygiene Important, If item 27 is marked other the any injury or other traumatic event, the I Pharmacist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) D'Agostino မ Helen Francis Α. Flaherty should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19628 Islander Street, Olney, Maryland 20832 Audrey M. Flaherty / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 ☐ Cremation 3 ☐ Removal from State Germantown, Maryland 10/18/11 All Souls Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Barber Funeral Home 20882 Box 5038, Laytonsville, MD 23a, Part 1. Enture e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): the burial-transit Cause (Disease or injury and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant a 5 Other (specify) Pregnant at time of death signed by the at I be detached for g P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Division of Vital Records, been sig should b Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an s certificate has b director, page 2 s autopsy performed? Yes 2 No ... ure Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this completely filled in the completely filled in the completely filled in the completely filled in the complete of To Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No 1 Natural Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number OLLU 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P 3 ASON 81 D 31. Date filed (Month 32. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:15 Virginia Ann Funkhouser October 19 201^Y1° Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign March 13, 1919 216-46-3148 92 **Director** 1 □ M 2 🕅 F Virginia Usual Residence of Decedent 28a-f shov at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Baltimore City Baltimore 1 Yes 2 X No ō 10e. Street and Number 10f. Zip Code must be 10g. Citizen of What Country? Funeral 23a 4301 Roland Ave. 21210 U.S.A. items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Force 0 ģ 1 Never Married 2 Married Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify: "natural", Completed 3 XWidowed 4 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16h Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than ife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Personal Residence 12 other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Robert Switzer Virginia Armentrout 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Weslie Wornom-daughter 10350 NW 11th St. Plantation, FL 33322 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) 11-12-2011 Rose Hill Cemetery Hagerstown, MD ture of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head railure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) men Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir the Hospital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death, the Funeral Director: After this certificate has been signed by the attending physician and ripletely filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death a Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital ၉ 1 🗌 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 Yes 2 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day,

Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20

State of Maryland / Department of Health and Mental Hygiene Valerie Ali Farver 1- For State Certificate of Death Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Time of Death Physician/ Month Day October 25, 2011 0030 hrs Medical Examiner Valerie Alice Farver c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington 14717 Pennsylvania Avenue Hagerstown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign California Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number **Funeral** Months Days Hours Director April 1,1974 37 559-47-8997 1 M 2 7 F Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location ā 10a. State 10b. County 1 Yes 2 X No Maryland Washington County Hagerstown 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 14717 Pennsylvania Ave. 21742 U.S.A. 238 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married 2 X No Yes Specify: White 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) of Health and Mental Hygiene.

If item 27 is marked other than ther traumatic event, the Medical 21215-0036 Homemaker Personal Residence 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Douglas Lane Murray Sharon Ann Harris Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Douglas L. Murray-father 14717 Pennsylvania Ave. Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 XCremation 3 Removal from State other 10-27-2011 Smithsburg, MD Smithsburg Crematory 4 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown 23a. Part I. Entgif the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and /Medical Death a Acute and chronic Narcotism Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and sician/Medical AMENDED 23a, 27, 28a-f, per me, g921 11-15-11 sm attending physician a X UNPENDED The law requires that the death certificate be Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 2 Fetal death Live birth 3 Ectopic pregnancy Month Dav Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown 된 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available certificate has been ector, page 2 should 24a. Was an autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) or Attending Physician: 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes After this 2 No 28a. Date of Injury (Month, Day, Year 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: 1 Natural injection of crushed medication 1 Yes 2 X No 5 Pending fd 10-24-11 fd 23:44 ę tablets 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State)14717 Pennsylvania .= found in residence within 24 hours a To the Funeral I (Specify) the Hospital 4 Homicide Hagerstown, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number October 25, 2011 O.C.M.E. 20aa 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 12, 2011 Year Alma Viola Gaumer 02:10 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Allegany Frostburg Village Nursing Care Center Frostburg Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9 Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 💢 F Days 82 February 17, 1929 Pennsylvania Director 175-24-0482 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Allegany Frostburg Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20553 National Hwy Funeral U.S.A. 21532-12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Homemaker permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygies Important: If Item 27 is marked other t any injury or other transmitters. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Clay Murray Elsie Fuller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Donald Gaumer 52 Little Savage Lane Frostburg Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Greenville Cemetery Pennsylvania Greenville October 15, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 Tuhole. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CUTE disease or condition resulting in death) Due to (or as a consequence of): NEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by DEMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No Yes 2 No Be

Ph sician/ Medical **Examiner** and -tran attending physician for use as the buria the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the hed signed by t

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the Funeral Director: After inpleted filled in by the funeral

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Certificate:

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an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at

within 72 hours after death with the Maryland

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event, the

Baltimore, Maryland 21215-0036

25. Was case referred to medical		26. Place of Death (Chec	k only one)
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	outpatient 3 DOA Other: 4 Nursing H	ome 5 Residence 6 Other (Spec
27. Manner of Death 1 ☑ Natural 5 ☐ Pending		Time of 28c. Injury at work?	28d. Describe how injury occurred

1 Natural 2 Accident	5 Pending Investigation	(IVIONTH, Day, Year)	injury
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	

factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)

a. Certifier	1 Certifying Physician: To the best of my knowledge, death occur	ed at the time, date and place, and due to the c	ause(s) and manner as stated.									
(Check	2 Medical Examiner: On the basis of examination and/or investigation	n, in my opinion, death occurred at the time, date	and place, and due to the cause(s) and manner state									
only one)	3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
o. Signature an	d title of certifier	29c. License number	29d. Date signed (Month, Day, Year)									

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9. Mame	e and address of person who completed cause of death (Item 23a) (Type, Print)	Rd.
1 Date:	illed (Month Day Year) 22 Posistray's Signature	

32. Registrar's Signature

Cumberland MD 21502

State

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Physicia Medic		1. Decedent's Name Melvin			am		Gates						Ö11 ^{Yea}			
Examin		- '		ive street and i	number)								. County of D			
Funeral Director		5. Social Security Nu 222-26-	umber 6	. Sex	7. Age	(In yrs. la	st birthday) Yrs.	If Under 1 Year Months Days	If Und	ler 24 Hrs.	8. Date of Birt	h 6 ^(ear) 1	g.	Dirthola	ce (State o	r Foreign
	'n	Usual Residence of 10a. State					, Town or Lo									ty Limits
e Maryla r 28a-f s notified	Director	WV 10e. Street and Num		eral			Ke									2 🗆 No
n with th	Funeral I		Chandell	Street	William Gates **Invest of number** Ab. City, Town, or Location of Death Cumber Investor (Combendary) Ac. Country of Death Allegany											
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d 2 should alth and N 1 27 is ma er trauma		19a. Informant's Na Sue Ga	me/Relationship tes	(Type, Print)	wife)	19b. Mailir 1 4	g Address (Street a	and Num	nber or Rura Street	Route Number	r, City or yser	Town, State,	Zip Cod	% 26	726
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Integration of Health and Mental Hygiene. The many injury or other traumatic event, the Medical Examiner must be notified at once.					rom State				e,P.	Α.΄						MD
permit. F Departm Importa any inju		21. Signature of Fur				L	22					land,	MD 2150)2		
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hysician/ Medical Examiner		disease or condition resulting in death)		a. Due	to (or as a	conseque	ence of):	varia	Co	ren				7	4	
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atn certificate be attending physic for use as the bu	Nedica			d										\perp		
ires trat the death certificate be signed by the attending physic d be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	1 □ L 4 □ P	ive Birth 2 regnant at t	Fetal	death 3		бу							Year
uires tnat tr n signed by uld be detad	þ	Part II. Other signifi	icant conditions	s contributing t	to death bu	t not resu	ılting in the u	nderlying cause giv	ven in Pa	art I.					_	
aw requas been 2 shoul	Completed										24a. Was a	an	24b. Were	autopsy to comp	y findings a	available
	Be Con	25. Was case referre	ed to medical	<u> </u>				26. Pl	ace of D	eath (Check	1 🗆 Yes	rmed?			□ No	
rnysicia this cer al direct	욘	examiner? 1 Yes 2 2	No .					t 3 DOA Othe	er: 4 📑	Nursing Ho	me 5 Resid			pecify)		
eath. or: After the funer	Certificate:	1 Accident 3 Suicide	5 Pending Investigat 6 Could no	tion (N				work	?		28d. Describe h	ow injur	y occurred			
tal or Att		4 Homicide	determine	28e. Pla	ace of Injury uilding, etc.	y - At hor (Spec <i>ify)</i>	me, farm, stre	eet, factory, office						Rural Ro	oute Numb	oer,
To the robpilat or Actending Prysician: The within 24 hours after death. To the Funeral Directors After this certificate i completed filled in by the funeral director, pag	Medical	(Check 2	Medical Exa	miner: On the	basis of exa	mination	and/or invest	igation, in my opinio	on, death	occurred at	the time, date a	nd place	and due to t	he cause	e(s) and me	anner stated.
withi To th		29b. Signature and t	itle of certifier	llin	ma			29c. License	e numbe	565		29d. Da	ite signed (Mo	onth, Da	y, Year)	
nds		30. Name and addre	ess of person wh	o completed c	eause of dea	ath (Item	23a) (Type, P	rint)		Liu	se he 1	77	2/1	-02	,	
Stat Registra		31. Date filed (Month	T 0 7 20	11 8.	. Registrar	's Signatu	ire Soar	es ?					-/3			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gaskins October | 2011 5:56A William Hancock Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 301 Juneberry Way Apt. 1-D Glen Burnie Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** X M 2 □ F Hours 9/10/1955 56 Washington, D.C 227-74-5631 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County iral", or items 23a or 28a-f shorex Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits rector 1 Yes 2 No Maryland | Anne Arundel Glen Burnie 靣 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21061 301 Juneberry Way Apt. 1-D Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. 1. Marital Status Armed Forces? 1 Never Married 2 Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify ed other than "natural", event, the Medical Exar Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important if item 27 is marked other than any injury or other transmitted. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Not Applicable Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sherron Davis Richard H. Gaskins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1208 Chrisland Court, Annapolis, MD 21403 Sherron G. Greulich/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donardon 5 Other (Specify) cemetery, crematory or other place, Oak Hill Cemetery 10/20/2011 Washington, D.C. 21. Signatu 22. Name and Address of FacilityGeorge P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Examir Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform certificate 2 🗌 No 1 Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 X Yes 2 | No မ 1 🗌 Inpatient 2 🗎 ER/Outpatient 3 🗍 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral ithin 24 hours atter resum o the Funeral Director: After th 27. Manner of Death 28c. Injury at 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician. To Medical Examiner (Certifying Nurse Pia on the pasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

within To the

31. Date filed (Month, Day, Year) OCT 1 8 2011

29b. Signature and title of certifie

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephan R. Izzi, M.D. 7575 Ritchie Highway, Glen Burnie, MD 21061

29c. License numbe

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35112 Certificate of Death 1. Decedent's Name (First, Middle, Last) Sarah Ruth Guynn 2. Date of Death 3. Time of Death Physician/ October 14, 2019 1:04 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Allegany Examiner Westernport 22212 Horserock Road 7. Age (In yrs. last birthday) 5. Social Security Number 234–42–7694 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 21 9. Birthplace (State or Foreign **Funeral** Days Hours Min 1 M 2 X F Maryland ືາ 926 Dec. Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City, Town or Location Director Mineral Keyser WV 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 26726 Rt. 1, Box 136A Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. "natural", or ģ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. Specify: white Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 ▼ Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Housework Homemaker unknown permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumastical. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosetta Harvey Hubert Bever 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Guynn JR/ son 22212 Horserock Road, Westernport, Maryland 21562 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State Potomac Mem. Gardens 10/17/2011 Keyser, West Virginia 4 Donation 5 Other (Specify)

Physician/ Medical 21. Signature of Funeral Service Licensee

Physician/Medical Division of Vital Records, P.O. Box 68760 ۶

	1. T. Migre	15 oak	111 Chur	ch St,	Weste	rnport, M	Maryland	21562
	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	a. SCUDVEW CAR Due to (or as a consequence of) b.		,				Approximate Interval Between Onset and Death
	resulting in death)	Due to (or as a consequence of)	4.4	A				
>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of)	ARTER	y Dis	EAS)			
	Cause (Disease or linjury that initiated events resulting in death) Last	C. Due to (or as a consequence of)					·	
		d						
, , , , , , , , , , , , , , , , , , ,	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1	3 Ectopic preg 5 Other (specif				23d. Date of de Month	livery Day Year
	Part II. Other significant conditions c	ontributing to death but not resulting in	the underlying caus	e given in Part	1.			o the cause of death?
, old						24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of
	25. Was case referred to medical examiner?		2	6. Place of Dea	ath (Check or	nly one)		
	1 Yes 2 PNo	Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA	Other: 4 \(\supers N	ursing Home	e 5 Residence	6 Other (Spec	residence
	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Tin inju	ıry 200.	Injury at work? 1 □ Yes 2 □	280	d. Describe how inj	ury occurred	

22. Name and Address of Facility Boal Funeral Home

Examiner To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page ٤ Certificate: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DUTUBER 17 2011 D26907 Hsylhi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502 31. Date filed (Mon Registrar's Signatur State www Registrar **ORIGINAL**

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Amend Item 25 State of Maryland / Department of Health and Mental Hygiene per me,g921,11/01/2011dhb
Registrar Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 25,2011 21:52P. M Margaret Catherine Hammond Medical 4b. City, Town, or Location of Death Silver Spring 4a. Facility Name (if not institution, give street and number) County of Death
Montgomery **Examiner** Holy Cross Hospital 8. Date of Birth
Feb. 21,1924 5. Social Security Number yrs, last birthday If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 - M 2 XF Months Mary Tand 87 577-34-8388 **Director** Usual Residence of Decedent filed within 72 hours and tall Hygiene.
ed other than "natural", or items 23a or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗓 No Prince George's Beltsville Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20705 4920 Olympia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14, Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) PG CO. School Board Cook Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file and Mental H Hall Edna Frank Elton Doyle permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Informant's Name/Relationship (Type, Print) 19b Majiling Address (Street and Number or Rural Boute Number City or Town, State, Zip Code) 705 William E. Hammond -husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State George Washington Cem 9/30/2011 1 X Burial 2 Cremation 3 Removal from State Adelphi, Maryland 4 Donation 5 Other (Specify) Signature of Funeral ervice Lio-Bonald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23e Part 1. Enter the disease or con shock, or heart failure. Ilist only Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest dry one cause on each line. Approximate Interval Between Onset and Death Physician/ Gastrointestinal Hemorrhage disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of). AMINER burial-trans APPROVEUB and Due to (or as a consequence of) resulting in death) Last CERTIFICATIO attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months?

1 Yes 2 X No
9 Unknown Year Month Day g 🗌 Unknown the detached Division of Vital Records, P.O. ģ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an • Hospital or Attending Physician: The law 24 hours after death.
• Funeral Director: After this certificate has k autopsy performed Yes 24 1 ☐ Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No. Hospital: ပ 1 Inpatient 2 XER/Outpatient 3 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🖸 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one 29b. Signat မ 25,2011 D 24348

State Registrar 30. Name and address of person who com

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31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

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MD HCH

1500 Forest Glen Rd. Silver Spring, Md. 2010

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

irman

Registrar

DHMH 17 Rev 7/2009

State

Dr. Harjit Sidhu, 925 Bishop Walsh Road, Cumberland, MD 21502

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

26 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State		State of N	Maryland		artment of H		d Mental H	ygiene)			
		Registrar 1. Decedent's Name (First,	Middle I ast)		Cer	tificate of D	eath	O Data of D	Reg. No	. 20		35	115
Physici Medi	cal		C	Gene Chad		Ielbig	1		2. Date of D Month 10		20 Ye	ear 011	3. Time of 10:10	Death) PM
Exami	ner	4a. Facility Name (if not ins)		4b. City, Town, or			40	c. County of I			
Funeral	_	Dennett Road Ma 5. Social Security Number	6. Sex	7. A	Age (In yrs. last i	birthday)	If Under 1 Year	Oaklan If Under 24 H		irth	9	Gar	lace (State or	r Foreian
Director		217-28-0046		⊉ M 2 □ F	83	Yrs.	Months Days	Hours M	lin. (Month, E)av (Par) 19/192	.8	Count	Oakland	
nd how at]	Usual Residence of Deceder 10a. State 10b. C	ent County		10c. City, To	own or Lo	cation					1	0d. Inside Cit	v Limits
flaryla 8a-f s tiffed	ect	MD	Gar	rett			N	⁄It. Lake F	Park				1 🛚 Yes	
the A		10e. Street and Number					10f. Zip Code	At. Bake I	ur K	10g. Ci	itizen of Wha	t Coun	try?	
h with	Funeral Director	PO Box 3026						21550				USA	1	
r deat	by Fu	11. Marital Status 1 ☐ Never Married 2 ఏ		12. Was Decedent Armed Forces			Vas Decedent of His FYes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Yes or No erto Rican, etc.))-	14. Race - A Black, V			
036 's afte ral", c		3 Widowed 4 Dir	-	Armed Forces' 1 X Yes 2 If Yes, Give Year or Dates.	1946	1	☐ Yes 2 🏋 No	Specify:			Specify:	W	'hite	
5-0 2 hour	plet	15. D (Specify only	ecedent's Edi	ucation le completed)	1	6a. Deced	lent's Usual Occupa	ation	vorkina	16b. K	Kind of Busin	_		
121 thin 7 sne. than the Me	Completed	Elementary/Seconday (0		College (1-4 or	r 5+)	life. Do	O NOT use retired)				Cox	l Ind	lustry	
Id 2	Be	12 17. Father's Name (First, Mi	iddle, Last)				Offer Off	Drag Lin	Name (First, Middle	e. Maiden		ii ind	ustry	
/landde find de finder	မ		J.	Edward Hel	lbig				,		nadderto	n		
Alan shoul and I is marraume		19a. Informant's Name/Rel		e, Print)	1	19b. Mailin	g Address (Street a	nd Number or	Rural Route Numb	er, City or	r Town, State	, Zip C	ode)	
e, N and 2 Health em 27		CharlesHelbig / Section 20a. Method of Disposition	on				oster Road, C	Dakland, N						
mor age 1 ant of it: If it		1 🗌 Burial 2 🛣 Cren			te ceme	etery, cren	sition (Name of natory or other place	1	Date	20c. L	ocation - Cit	-		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 ☐ Donation 5 ☐ C			The		rland Cremat Name and Address		.0/25/2011		Cumb	erlar	nd, MD	
Bal permi Depar Impo any ir		h	6-1	ruller	/		vid A. Burdoc	,	Home, P.A., 2	21 N. 2 ¹	^{1d} St., Oa	kland	i, MD 215	550
		23a. Part 1. Enter the disea shock, or heart failure	ase, or compl List only one	cations that cause cause on each lin	ed the death. D ne.	o not ente	r the mode of dying	, such as card	liac or respiratory a	arrest,			Approximate Interval Betw	veen
Ph, sician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_				ve Pulmon	ary Di	sease				Onset and D	
Examiner	ı			Due to (or as	s a consequend	ce of);								4
MALER	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying		Due to (or as	s a consequenc	ce of):						+		
ecuted and transi	Examiner	Cause (Disease or linjury that initiated events	7	Due to (and		0 .								
Records, P.O. Box 68760 The law requires that the death certificate be executed rate has been signed by the attending physician and page 2 should be detached for use as the burial-transit		resulting in death) Last	L	Due to (or as	s a consequenc	ce on):								
3760 ficate b g physic as the b	Nedical					-			_			\pm		
OX 687	Physician/M	IF FEMALE: 23b. Was decedent pregnar in the past 12 months?	11.	3c. If yes, outcome 1 ☐ Live Birth	e of pregnancy	eath 3	Ectopic pregnancy	,			23d. Date o	f delive	ry	
P.O. Box that the death or ned by the atten s detached for u	ysici	1 Yes 2 No		4 Pregnant 9 Unknown	at time of deatl		Other (specify)				Month		Day Ye	ear
hat the ed by detac		Part II. Other significant co	onditions con	tributing to death	but not resultin	ng in the u	nderlying cause give	en in Part I.	23e. Did	tobacco t	use contribu	te to th	e cause of de	eath?
ords, P.O. Be requires that the de been signed by the should be detached	ed by	Coronary Ar	tery D	isease					1🕱	Yes 2	□ No 3[Prob	ably 4 🗆 L	Jnknown
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Vital Rec sician: The la certificate ha irector, page 2	Con								perl	ormed? 2 K No	deat	:h?	2 No	
fital sician certifi rector	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 ☒ No		ospital:			Othor		heck only one)					
of V g Phys er this eral di	e: 10	27. Manner of Death		28a. Date of inj	tient 2 ER/ ury 28b	o. Time of	28c. Injury	4 Nursing	g Home 5 Res	idence 6	Other (S	pecify)		
on endin sath. or: Aft	licat	2 Accident	Pending nvestigation	(Month, Da	ay, Year)	injury	work? M 1 □ Y	∕es 2 □ No			,			
Division of Vital Records, tal or Attending Physician: The law requires its after death. al Director. After this certificate has been signed in by the funeral director, page 2 should by	Certificate:		Could not be determined	28e. Place of In building, et	jury - At home, tc. <i>(</i> S <i>pecify)</i>	farm, stre	et, factory, office		28f. Location City or To			Rural	Route Numbe	er,
Spital		29a. Certifier 1 Cert	tifying Physic	ian: To the best o	of mv knowledge	e. death o	ccured at the time,	date and place	and due to the c	ause(s) ar	nd manner a	s stated		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director.	Medica	(Check 2 L Med	lical Examine	er: On the basis of ϵ	examination and	d/or investi	gation, in my opinion eath occurred at the	 death occurre 	ed at the time, date	and place	and due to t	the cau	se(s) and man	ner stated.
To T		29b. Signature and title of co	ertifie	2 0	c. 1	V	29c. License			29d. Da	te signed (M		4 1	
	6	30. Name and address of pe	CK 16	moleted square f	death (Ideas on) (Time 5	int	D64302	2	10	121	<u></u>	011	
of	VΑ	Daniel Buckingha			- 10		,	l, MD 215	550					
Sta		31. Date filed (Month, Day, Y			rar's Signature	for	del.							
Registra	या	OCT 2	4 2011	Jenne	w. A.	19 11								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Elizabeth Louise Hanna 18, 2011 12:30 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin House Harwood 8. Date of Birth
(Month, Day, Year)
Jul. 9, 1941 Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months New York Hours 1 □ M 2 😿 F 70 Director 079-34-3009 Usual Residence of Decedent or 28a-f show th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2XXNo Davidsonville Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2542 Arbor Court 21035 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Armed Forces? 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Prince George's Elementary/Seconday (0-12) College (1-4 or 5+) 5+ County Public Schools Teacher permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Lawrence Owen Lucille Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9343 Sutter Drive, Tinley Park, IL 60487 Matthew J. Hanna - Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Lakemont Memorial 4 Donation 5 Other (Specify) 10-21-2011 Davidsonville, MD ardens operal Service Licer 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy, Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Due to (or se's consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events and I-transit The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknow been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has le 2 autopsy pade death? certificate 1 Tyes Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 1 Tyes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner assistated. only one) 29b. Signature and ti eath (Item 23a) (Type, Print) 30. Nume and address of p

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State Registrar

Box 68760

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Division of Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend 25, per me, g921 11-15-11 sm
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No.2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 14 Physician/ 0115 BARBARA ELLEN HATC H Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS Regional Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗶 F Days Hours June 8, T935 Months West Virginia 220-40-1534 76 **Director** Usual Residence of Deceder show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 Yes 2 X No MD Garrett Oakland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 21550 14625 Garrett Hwy. items Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian ural", or iterr I Examiner r 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White "natural" 3 - Widowed 4 - Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working of Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Genevieve Reckart Theodore Uphold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21550 John R. Hatch/Husband 14625 Garrett Hwy., Oakland, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Country Side Crematory Oct. 21, 2011 Davidsville, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. . Signatule of Funeral Service Lice Þ P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CARDIAC ARREST disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SPIRATORY Sequentially list conditions, if any leading to him redistricause. Enter Underlying SHOUKS Examine attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last CEREBRAL HEMORRHAGE CETTE CATION APPRIVED BY MEDI Due to (or as a consequence of): Physician/Medical The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death been signed by the a should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by NONE 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The 24 hours after death. Funeral Director: After this certificate? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical **Division of Vital** funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. o the hc. within 2/ To th (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/14/ 2011 OORE D7228 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12500 Willowbrook Rd., Cumberland, MD 21501 Charlie Moore, 31. Date filed (Month, Day, Year) 2. Registrar's Signature State 18 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HARD 011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** OSPITAL Move 6. Sex 1 **X** M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** Days Month, Day Ye Months Hours 1944 Virginia Jan. 231-58-2798 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Princess Anne Somerset 1 ¥ Yes 2 □ No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral **USA** 21853 30539 Bardwell Drive "natural", or items . Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) seafood 10 waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Fairy Louise Thornton Donald Lee Hall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 30539 Bardwell Drive, Princess Anne, MD 21853 Marianne Hall - wife Department of Hea Important: If item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Cremation 3 - Removal from State 1 K Burial 2 injury or Cape Charles, Virginia Cape Charles Cemetery 10/26/2011 5 Other (Specify) 4 Donaties P. O. Box 633 22. Name and Address of Facility 21. Signature Doughty Funeral Home Exmore, VA 23350 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2X10 Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? jo Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 performed Yes 2 2 No certificate 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? 2 1 No ၀ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) e Hospital or Attending Phy: 124 hours after death. e Funeral Director: After this leted filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending **✓** Natural work? Division 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours after

To the Funeral Dire

completed filled in b Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 2011 who completed cause of death (Item 23a) (Type, Print)

Box (

of Vital

State Registrar 30. Name and address of person

9 31. Date filed (Month,

DHMH 17 Rev 7/2009

PAUL

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-07844 State of Maryland / Department of Health and Mental Hygiene Margaret Ellen Jennings 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 2151 hrs Medical Examiner October 18, 2011 Margaret Ellen Jennings 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Worcester Showell 11647 Seahawk Lane If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months Days Hours Country) MD Director 218-72-0428 1 M 2 X F 65 15/1946 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 X No is 23a or 28a-f show e notified at once, 28a-f show Showe11 Director Worcester the Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21862 USA 11647 Seahawk Lane death with 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 Married 1 Never Married Yes permit. Pages I and 2 should be filed within 72 hours after of Department of Health and Mernal Hygiens.

Department If item 27 is marked other than "natural", on linjury or other trannastic event, the Medical Examiner in highry or other trannastic event, the Medical Examiner in 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 3 Widowed white ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Baltimore, MD 21215-0036 Homemaker Own Home 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) B James SUllivan Moulton Olga Incas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2.1.1.2.8 19a. Informant's Name/Relationship (Type, Print) Mary Moulton / sister 4925 Marchwood Perry Hall 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State First State Crem. 10/20/11 Millsboro, DE 4 Donation 5 Other Specify 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Fun all Se 108 William St., Berlin, MD 21811 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and nly one cause on each line . List √Medical Death a. Subdural Hematoma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Hospital or Attending Physician: The law requires that the death certificate be executed sician/Medical AMENDED ted by the attending physician detached for use as the burial -UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 2 Fetal death 3 Ectopic pregnancy Month Day Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown 판 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. Š 1 Yes 2 No 3 Probably 4 ✔ Unknown Atherosclerotic Cardiovascular Disease; Chronic Obstructive Pulmonary Disease; Completed 24b. Were autopsy findings available page 2 should 24a. Was an certificate has been Chronic Alcoholism prior to completion of cause of autopsy performed? death? Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical examiner? Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Subject fell FOUND 1 Natural 1 Yes 2 ✔ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 5 Pending 2145 hrs Oct 18, 2011 2 🗸 Accident Investigation 28f, Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) 11647 Seahawk Lane, Showell, MD determined (Specify) Single Family Home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 19, 2011 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Laron Locke MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State acke

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Please Type of Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Gordon Lee Jones 2. Date of Death Physician/ 50 70% Ochobe Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howar Columbis NUFFILLA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min 1 🌠 M 2 🗆 F 229-18-4192 90 **Director** .1921 Virginia Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director Anne Arundel Severna Park MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? must be Funeral items 23a 21146 USA 562 Arundel Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1942 1 X Yes 2 \(\) No 1066 14. Race - American Indian, Examiner Black, White, etc. ö 1 Never Married 2 Married þ Maryland 21215-0036 1966 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White "natural", Specify. 3 - Widowed 4 - Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+ NASA Logistics Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) မ Blanche Thomas Martha Blanche Bundy Meno Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Severna Park, MD 21146 562 Arundel Drive Katharina Jones / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Crownsville, MD MD Veterans Cemetery 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Barranco & Sons, P.A. Severna Park Funeral Home
495 Ritchie Hwy, Severna Park, MD 21146 Severna Park, MD 21146 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician; The law requires that the death certificate be executed nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Records, P.O. Box 68760 use as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No jo Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy performed 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 🗌 Yes ၉ 1 Inpatient 2 🗆 ER/Outpatient 3 DOA Manner Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deatl Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 odobes 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rever neck Road Balhond Bade 201-109 Saba a 31. Date filed (Month, Day, Year) State OCT 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ October 2011 6:45 P. M Robert H. Johnson, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick 5733 Buffalo Rd. Mt. Airy 8. Date of Birth 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) MD Age (In yrs. last birthday, **Funeral** Days Months 1 🛛 M 2 🗆 F Hours 0572871939 **Director** 216-36-7305 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme "not any injury or other trainme 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 2 🌁 No Frederick Mt. Airy 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21771 5733 Buffalo Rd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by If Yes, Give Year or Dates 1 Tes 2 No Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hughes Johnson Loretta Stewart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mt. Airy, MD 21771 Diana Johnson/wife 5733 Buffalo Rd. 20a. Method of Disposition
1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 10/18/11 Stauffer Crematory Frederick, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cancer disease or condition Medical resulting in death) Due to (or as a Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Certificate: To Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 27. Manner of D ath 1 Natural 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 5 Pending 1 Yes 2 No Μ Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manual in Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed

Q

State Registrar Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 7CHD, PRO Certificate of Death าดุโรโภ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 15-2011 Dorothy B. Jessup Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Talbot at Easton

3. Time of Death 1839 Memorial Hospital Easton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 12–18–1931 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Min. 79 Days Hours 1 🗆 M 2 💢 F Washington DC 231-44-2899 Yrs Director Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No MD Talbot Easton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 610 Dutchmans Lane USA 21601 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💹 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administration Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James E. Ball, Jr. Dorothy Corsette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisbeth J. Jordan Daughter 120 Governors Way South, Queenstown, MD 21658 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Chesapeake Cremation 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/17/2011 Stevensville, MD Center . Sig of vir ral Service Licens Pellows, Helfenbein & Newnam Funeral Home, P.A. 200 S. Harrison St. Easton MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ neumon disease or condition Medical resulting in death) Due to (or as a consequence of). **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnan 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months Pregnant at time of death Yes 9 I Inknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been si should 24b. Were autopsy findings available 24a. Was an s certificate has the director, page 2 s prior to completion of cause of death? performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this s after death.

I Director: After this d in by the funeral d 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

30. Name and address of person who completed dause of (Item 23a) (Type, Print)

15 State Registrar

31. Date filed (Month, Day, Year) strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Oct 2011 SAMUEL LOUIS KITCHEN 3:00 pm 17 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SUNRISE ASSISTED LIVING COLUMBIA HOWARD 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days Hours Min. 1X M 2□ F ,1927 North Carol Director 242-36-0609 83 Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location show r than "natural", or items 23a or 28a-f sho the Modical Examinar must be notified at 1 ☐Yes 2 XNo Director VA Loudoun Lovettsville 10f. Zip Code 20180 10e. Street and Number 10g. Citizen of What Country? 39734 Overlook Knolls Road U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2X Married XYes 2 □ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 45-48 1 ☐Yes 2X No White Specify ò Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ne any injury or other traumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) Health Care Products PLANT MANAGER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Sumpter Kitchen Ruby Griga 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20180 39734 Overlook Knolls Rd. Lovettsville, VA Elaine Myers Kitchen/wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crem 10/19/11 Alexandria, VA 4 ☐ Donațion 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Loudoun Funeral Chapel 158 Catoctin Circle, SE, Leesburg, VA20175 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 1 botos disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. signed by the a 1 Tyes 2 TNo 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 3 ☐ Probably 4 ☐ Unknown 1 X Yes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 □ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 43515+00 Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. eral Director: A 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined after 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Showder

Registrar DHMH 17 Rev 1/2001

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Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <u>1</u>8^{Day} 10 Month Physician/ 2011 3:52 PM James Edward Kopper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Days Hours 10/5/1946 65 MD 217-50-0682 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12052 Assateague Way 21811 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give 3 Divorced white Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Owner/Operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Elsie Wirts John Bernard Kopper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12052 Assateague Way, <u>Berlin, MD 2181</u> Janice Kopper / wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State First State Crem. 10/19/11 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, DE 22. Name and Address of Facility Burbage Funeral Home of Funeral Service Lice 108 William St., Berlin, MD 21811 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 1000m Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Physician/Medical Examiner Due to or as a consequence of thany knading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): physician or Attending Physician; The law requires that the death certificate be IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year page 2 should be detached for 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No certificate of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖪 No Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of completed filled in by the funeral 28d. Describe how injury occurred 5 Pending Natural Division Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of cer 29c. License number 5361 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Berlin MD 21811 733 MD Bajer 32. 31. Date filed (Month Day, Begistrar's Signature State Registrar

DHMH 17 Rev 7/2009

18/101

KOPPER

James

Amend #15 per 11-07730 per	FI	o, AACO Health 10–18–11 Please Type or Print in Black Indelible Ink. Ensure All Copie	es Are Lea	ible.	
Susan V. Kellog	g	KAH State of Maryland / Department of Health and Mental H	ygiene	201	3512
mend #5 10/21 Physici	an/	1. Decedent's Name (First, Middle,Last)	2. Date of Death	g. No.	3. Time of Death
Medical Exami	ner	111111111111111111111111111111111111111	Month October 15		1056 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Washington Medical Center 4b. City, Town, or Location of Death Glen Burnie		4c. County of Death Anne Arundel	
Funeral Director		5. Social Security Number 043-34-3446 1 Months Days Hours Min	_	(MM/DD/YYYY) 9. Bir /1943 Co	
ow any		Usual Residence of Decedent			10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	
ith the h 23a or notified		1081 Snow Hill Lane 21054 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St		U.S.	
Baltimore, MD 21215-0036 pemit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Specify Cuban, Mexican, Puerto 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No specify:		White, etc.	nite
16 n 72 hours na "natur ical Exam	Completed t	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of volume for during most of working life. DO NOT use retired to the control of the con		16b. Kind of Business/	
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MD 2 12 shoul th and N 27 is m umatic	Ţ	19a. Informant's Name/Relationship (Type, Print) Robert H. Kellogg (spouse) 19b. Mailing Address (Street and Number or F			, Zip Code)
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	1	3- 2 (851 Annapolis RD,	Gambril.	ls, MD 210:	54
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£xaminer		or condition resulting in death) Due to (or as a consequence of):			
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tal Records, P.O. Box 68760, cin: The law requires that the death certificate be executed certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit	Physician/Medical	UNPENDED AMENDED			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Str or Town, Sta		ral Route Number, City
To the Hosp within 24 ho To the Fune	Medical C	29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.	due to the cause t the time, date ar	(s) and manner as state and place, and due to the	ed. e cause(s)
P. S. P. S.	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
		30. Name and address of person who completed cause of death (Item 23a)		October 16, 2011	
lev		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35126 - For State Registrar State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ ETHELDA 2011 1638 NADMI KIMBO Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 121 Clay St. Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 219-30-3703 Director 1 M 2 F March 7 1930 81 Maryland Usual Residence of Decedent 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a f shov any injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 121 Clay St. 21401 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married ģ 1 Yes 72 hours after 2 X No 21215-0036 1 Yes 2X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th 0 <u> Hostess</u> Galway Bay Pub Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Brooks Margaret Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard L. Kimbo(Husband) 121 Clay St. Annapolis, Md. 21401 Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b.PlackoDiapositien (Name of cemetery, crematory or other place) 1 X Burial 2 \square Cremation 3 \square Removal from State Memorial Gardens 10-22-11 Davidsonville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Winame Reeseof & CilitSons Mortuary, 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Monard Dea Physician/ EMENTIA disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 1 Yes 2 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Division of Vital Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Within 2 29b. Signature and title of ca D 21438 me and address of person who dompleted cause of death (Item 23a) (Type, Print) DEFENSE HWY ANNAPOLIS MOZIYOI NTA MO 445 -late 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Registrar

2011

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Baltimore, Maryland 21215-0036 To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

	1	For State Registrar	Plea	se Type or P State of		d / Dep		Health and	Mental Hygi	_	35128	
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permit. Page 1 Department of Important: If it any injury or o		1 Burial 2 Donation 21. Signature of Fur	5 Other (S	icensee	St.	Mich.	natory or other pacel's Ce	metery 10		Frostburg		
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To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2	9 P	examiner?	1 100	28a. Date of (Month,		ER/Outpatie 28b. Time of injury	nt 3 DOA	other: 4 \(\square\) Nursing	Home 5 Reside	ence 6 Other (Spe w injury occurred	ecify)	
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To the Host within 24 ho To the Fune completed f.	Medical	(Check 2	☐ Medical E	Physician: To the bes xaminer: On the basis Nurse Practioner: To	of examinatio	n and/or investy knowledge,	atigation, in my or death occurred a 29c. Lice	inion, death occurred	d at the time, date an place, and due to the	d place, and due to the cause(s) and manner a	e cause(s) and manner stated as stated. oth, Day, Year)	
91		30. Name and address	ess of person	who completed cause	1	7	10 U	lenn St.	Culmberter	d MD 2	1502	
State Registra		31. Date filed (Monti	NOV ()	3 2011 32. R/S	istrar's Signa	ture	Bank I					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienefor State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Day 16 Physician/ 21:40 PM John Lower Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner university of Naryland Medical center Baltimore <u>Baltimore</u> If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number Sex 1 M 2 D F **Funeral** Days Hours Min OCt. 24 Year) 1947 MaryTand 214-48-4942 63 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov at 10a. State 10b. County 10c. City, Town or Location Director must be notified 1 X Yes 2 No Frederick MD Frederick 10f. Zip Code 10g. Citizen of What Country? ŏ 10e. Street and Numbe 23a USA 21701 1406 Pinewood Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status item 27 is marked other than "natural", or iter other traumatic event, the Medical Examiner Armed Forces? o i 1 Never Married 2 Married by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: 3 Widowed 4 X Divorced White Completed 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Parts Truck Driver 1.0 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental ၉ Ruth Maryetta Houser John William Lowery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health 1406 Pinewood Drive, Frederick, MD Robert Carpenter / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of Department of Important: If it any injury or o cemetery, crematory or other place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Hagerstown, Maryland 10/20/11 Rest Haven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Robert de Edre Baffrey & Son Funeral Homes, P.A. Signature of Funeral Service License 1201 North Market Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Esophageal
Due to (or as a consequence of): Physician/ Adenocarcinomo disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) the burial-transit Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 attending p IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Live Birth 2 Fetal deat
□ Pregnant at time of death signed by the a Yes 2 No 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Kunknown Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has this certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 K No 1 K Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending ☐ Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1659670214 10/16 MD JUSTIN BriTTON MD who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 0 Medical Center GIRREMES, Baltimore MI Maryland 21 University S. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 For State Registrar 351 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 14. James Andrew Lark, Sr. Öctober 2011 5:20 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Devlin Manor Health Care Center Cumberland Allegany 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/09/1944 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Min 1 X M 2 □ F Months 67 Director 215-42-2609 Marvland Usual Residence of Decedent 28a-f shov 10a. State or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with t Funeral USA 10301 Christie Road, NE 21502 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 \(\mathbb{N} \) Yes 2 \(\mathbb{N} \) No 1967—

If Yes, Give

Year or Dates.

1973 Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver should be filed with and Mental Hygien is marked other ti injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lark ဂ Myrtle Paron Andrew Kesner permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12328 Shadoe Hollow Road, Cumberland, MD Norma Hudson / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cumberland Crematory 10/15/2011 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Cumberland, MD 4 Donation 5 Other (Specify) Sign tury of Funeral Selvice Deensee Adams Family Funeral Tome, P.A. 22. Name and Address of Facility 21502 404 Decatur Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ vonan disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No for Pregnant at time of death Month Day Year the 3 9 🗌 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Azciden 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has k page 2 autopsy performed? Yes 2 1 No certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Other: 4 XNursing Home 5 Residence 6 Other (Specify) Hospital မ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No death. Accident Investigation within 24 hours after death

To the Funeral Director:,
completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Flaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) October 14, 2011 D33280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunil K. Guptă, M.D., 625 Kent Avenue, Cumberland, MD 21502 nxs

State

Registrar

31. Date filed (Month, Day, Year)

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₱32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 24a per doc g921 11-3-11 vt
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 LEVENDUSKI 2:00 a.M VIOLA SARAH October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Fahrney-Keedy Home Boonsboro Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours Min. Director 219-20-1939 88 Maryland 1923 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No Smithsburg Maryland Frederick 10e. Street and Number 10f, Zip Code "natural", or items 23a or 10g. Citizen of What Country? Funeral 13621 John Cline Road 21783 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or by 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Shoe Factory Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William G. Eccard Wolfe 0rpha Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Phillips/daughter 316 Botany Drive, Martinsburg, WV 25404 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Garfield U. MethodistOct.31,2011 Garfield, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 504 Main Street 22. Name and Address of Facility Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, of heart failure. List only one cause on each line. Approximate Interval Between shock, of heart failu Immediate Cause (Final aille Physician/ disease or condition Medical resulting in death) Due to (or as a o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a co Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the day, rlying cause given in Part II. 23e. Did tobacco use contribute to the cause of death? ğ unso 1 ☐ Yes 2 🗹 No , 3 ☐ Probably 4 ☐ Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 2X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ဂ္ 1 Yes 4. Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 🗌 No Investigation Accident hin 24 hours after death the Funeral Director; Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗔 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 31. Date filed (Month State Registrar

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evendushi

21215-0036

Maryland

Baltimore,

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Month Year Barbara Jean Leiboldt 10:12 PM Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Year Sept. 11, 1942 9. Birthplace (State or Foreign Country) Maryland 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Hours 1 🗆 M 2 💢 F 218-40-4023 69 Director Usual Residence of Decedent show 10a. State 10b. County notified at the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No Maryland Washington Boonsboro 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral with 1 USA 21153 Keadle Road 21713 permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?,
1 Yes 2 ANo Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔽 No Specify. Specify: White 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12 \end{array}$ College (1-4 or 5+) Publishing Company Graphic Arts other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Maurice Samue1 Pryor Edna Louise Grossnickle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21153 Keadle Road, Boonsboro, Maryland 21713 James D. Leiboldt/husband f Health 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of H Important: If ite any injury or ot once. cometery, crematory or other place)
Grossnickle Brethren Oct.31,2011 1 X Burial 2 Cremation 3 Removal from State Myersville, Maryland 4 Donation 5 Other (Specify) 504 Main Street 21. Signatur 22. Name and Address of Facility ala Ricketts Funeral Home Myersville, MD 21773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ph_sician/ Medical Due to (or equence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) burial-transi Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Pregnant at time of death signed by the a d be detached for 9 Unknown 9 I Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by IMMUNOSUS Ression Division of Vital Records, 1 Pes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an AMY WID OSIS page 2 autopsy perform death? 1 Yes 2 Z 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital ည 1 \(\text{Yes} 1 Dopatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at iniury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

of person who completed cause of death (Item 23a) (Type, Print) Lefferom BLVD SMITMIBURG OV 22911 31. Date filed State Registrar

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Medical Ex Certifying

miher: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

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e Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 25 per me, g921,11/01/2011dhb
Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mayhew Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Allegany Cumberland Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth 1 M 2 QF Days Hours Oct 27 **Director** 219-78-6206 55 Usual Residence of Deceden items 23a or 28a-f show ier must be notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 202 Memorial Avenue Apt. 1F 21502 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗖 No "natural" Completed 3 Widowed 4 Divorced white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Catherine Shank unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number 1 Frederick Street d Number or Rural Route Number, City or Town, State, Zip Street Cumberland MD 21502 Kim Clair per, rep 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ō Department of Important: If any injury or Scarpelli Funeral Home, P.A. 10/6/201 MD Cresaptown 4 Donation 5 Other Specify) 21. Sign ure of uneral Service icensee 22. Name and Carrell Full Eral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Part 1. Inter the disease, or complications that caused shock, or heart failure. List only one cause on each line 23a. Part 1 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) for use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) NAPPROVED BY MEDICA signed by the attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year page 2 should be detached ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death' performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number ss of person who completed cause of death (Item 23a) (Type, Print) Notional Huy. LaVale, MD State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mulligan Rose Marie Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Cumberland Allegany WMHS-RMC 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country)PA 1 - M 2 - F Months Days Hours (Nov 27,1 ear) 1939 215-36-9473 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. Coun 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director MD Allegany Cumberland 1 XYes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21502 USA 115 West Industrial Blvd. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ō ş 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates permit. Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar white 3 Widowed 4 Divorced Completed 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)

Meriam Wilhelm 17. Father's Name (First, Middle, Last) မ Edward James Snyder 19a. Informant's Name/Relationship (Type, Print)
Pamela Patch 19b. Mailing Address (Street and Number of Pural Route Number, City or Town, State, Zip Code) 21502 405 South Cedar Street Cumberland MD 21502 daughtei 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 3 Removal from State Restlawn Memorial Gardens 10/15/20 MD LaVale n 5 Other Specify) 22. Name an charpellif Faireral Home, PA Funeral Servio nature o 108 Virginia Avenue: Cumberland, MD 21502 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1 Enter the disease, or complications that shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) min Medical Due to (or as a consequence of **Examiner** Sequentially list conditions cause (Disease or iinjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 as signed by the attending I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown P.O. inificant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 X No 3 Probably 4 Unknown should Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident injury 5 Pending Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certi-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 517 Oktown Rd. Cumberland, MD alsos.

Registrar DHMH 17 Rev 7/2009

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Rapirthan M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Miller Jr. 2048 Gerald 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 1MHS-Regional Medical Center Cumberlana 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Date of Birth **Funeral** 1 🗙 M 2 🗆 F Country)MD Sep 26 219-52-6388 65 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Funeral Director MD Allegany Cumberland notified 1 X Yes 2 No 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code ò ms 23a or must be n 501 Baltimore Avenue 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) Specify: 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ò þ Baltimore, Maryland 21215-0036 Vietnam white "natural", Completed 3 Divorced 4 Divorced ed other than "nature event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Heath and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Tire Company tire builder Be 18. Mother's Name (First, Middle, Maiden Surname)
Leona V. Brinkman 17. Father's Name (First, Middle, Last) မ Gerald V. Miller, Sr. 19a. Informant's Name/Relationship (Type, Print)
Donna Willer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21502 501 Baltimore Avenue Cumberland MD 21502 wife 20a. Method of Disposition 1 D Burial 2 D Crema 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 🗆 Burial ion 3 Removal from State Scarpelli Funeral Home, P.A. 10/4/201 MD Cresaptown on 5 Other (Specify) Sanature 22. Name an Scarpelly Furtheral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Part 1. shock, Metastic Immediate Cause (Final Ph_sician/ MHEAVS disease or condition Medical resulting in death) Examiner Monta Sequentially list conditions. Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of): physiciar To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 ass attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 certificate 2 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 2 No 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Tes 2 No Investigation Could not be within 24 hours after death

To the Funeral Director: / Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 5

State Registrar Ste. 204 Cumberland, MD 21502

Name and address of person who completed cause of death (Item 23a) (Type, Print) tuma Shakil M.D. 635 Kent Ave

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GARY LEE MILLER, SR. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Allegany Western MD Regional Medical Center Cumberland If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Months Maryland 08 723 71948 220-58-0595 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 No MD Allegany Cumberland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 12909 Bowling Street U.S.A. 21502 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc 1 Never Married 2 X Married Yes 2 No þ Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Allegany Co.Bd. of Ed. permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other trainmate. Elementary/Seconday (0-12) College (1-4 or 5+) and Retail Store Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leona Gay Miller (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Miller / Wife 12909 Bowling Street, Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State Restlawn Meml.Gardens 10/06/2011 LaVale, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Upchurch Funeral HOme, P.A. 21. Signature of Funeral Service Licen ee 21502 202 Greene Street, Cumberland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final PULMONAR Physician/ EMBOUSM disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last -tran and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death signed by the all Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACDIOMYOPA 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 or autopsy perform 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) iniury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar

William Lamm, M.D.

OCT 0 7 2011

31. Date filed (M

MS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
William Lamm, M.D. - 12500 Willowbrook Road, Cumberland, MD

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 8, 2011 Physician/ Cvnthia McCagh 2252 Ann Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WMHS-RMC Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Birthpiac Country) MD 1 M 2 D.F Months Days Hours Oct 25 1949 Director 217-54-6855 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Allegany Cresaptown 1 XYes 2 No 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? the Medical Examiner must be Funeral 14797 Belli St. PO BOX 5174 21502 USA items within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 'natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify Completed white 16a. Decedent's Usual Occupation 16b. Kind of Business Industry teath and Mental Hygiene.

n 27 is marked other than "n pr traumatic event." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Callege (1-4 or 5+) Registerd Nurse WMHS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ones. George Washington Sites Helen Rita Glencoe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14797 Bell St. PO BOX 5174 Cresaptown MD Edward McCagh MD 21502 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Conation 5 ☐ Other (Specify) Restlawn Memorial Gardens 10/12/2011 LaVale MD 21. Synature of Funeral Serv 22. Name and Address of Fecility Paral Home, PA Licensee 108 Virginia Avenue: Cumberland, MD 21502 Part 1 Enter the disease, or complications that cause d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 ase yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? ò Month Year To the Hospital or Attending Physician: The law requires that the deal within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 1 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work? 1 Yes 2 No 1 Natural Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated crifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			11091011	ertificate of Death		ne . _{No.} 2011 35138
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Kelsey Mackell		2. Date of Death October	- Dal 4 2011 3. Time of Death 6:00A M
John .	Examin		4a. Facility Name (if not institution, give street and number) 803 Waterview Dr.	4b. City, Town, or Location of Death Pasadena		4c. County of Death Anne Arundel
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, $217-52-4464$ 1 X M $_2$ F 62 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Feb 24	9. Birthplace (State or Foreign Country) 1949 Maryland
	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L			10d. Inside City Limits
	ne Mar or 28a notifi	Director	Maryland Anne Arundel Pasad 10e. Street and Number	10f. Zip Code	100	1 ☐ Yes 2 🕅 No
	with the s 23a c ust be	Funeral	803 Waterview Dr.	21226	109	USA
920	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4X Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1X☐ Yes 2 ☐ No If Yes, Give Year or Dates. Vietnam	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
Maryland 21215-0036	n 72 hour s. an "natu Medical	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	ing 16I	b. Kind of Business/Industry
121	d within lygiene. ther tha nt, the N	Be Cc	12th 0 Sh	ipyard Police		Gederal Government
land	ld be filed Mental Hy, arked oth atic event	To B	17. Father's Name (First, Middle, Last) David H. Mackell		e (First, Middle, Maid D. Chapm	,
Aan	should and Me is mar raumati			ling Address (Street and Number or Rura		
re, N	f Health item 27 other tra		20a, Method of Disposition 20b, Place of Disp	Waterview Dr. cosition (Name of		c. Location - City or Town, State
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot once,		1-2-1-37			Crownsville, Md.
Ball	permit Depart Impor any in			Wman: Reeser & Son 1922 Forest Dr.		_
	Ph, si ian/		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line. Immediate Cause (Final			Approximate Interval Between Onset and Death
	Medical Examiner		Due to (or as a consequence of):	ISCULAR ACCI	DENT	
1	10	iner	if any, leading to immediate cause. Enter Underlying	LLADOW		
	icate be executed physician and is the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
209	ite be e hysiciar the buri	dical	d			
	for the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. In the feath is certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
P.O.	that the ned by e detac	y Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
rds,	requires been sig should b	ted t	VASCULAR DEMENTIA		1 🗌 Yes	2 ☐ No 3 ☐ Probably 4 🖼 Unknown
Reco	vysician: The law re nis certificate has bu I director, page 2 sh	Completed by			24a. Was an autopsy performed	
/ital	sician; certifi	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpution: 3 ER/Outseti	26. Place of Death (Check		a∏ au _ (2 _ '(2)
Division of Vital Records,	nding Phys tth. * After this e funeral di	cate: To	1 ☐ Inpatient 2 ☐ ER/Outpati 27. Manner of Death 1 ☐ Inpatient 2 ☐ ER/Outpati 28a. Date of injury (Month, Day, Year) injury Accident Investigation		28d. Describe how in	e 6 ☐ Other (Specify) njury occurred
Divisio	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director, After this completely filled in by the funeral in the	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
_	e Hospit 24 hour e Funera letely fills	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge of the control of the best of my knowledge of the control of the best of my knowledge of the control of the best of my knowledge of the control of the best of my knowledge of the control of the best of my knowledge of the control of the best of my knowledge of the control of the best of my knowledge, death of the control of the best of my knowledge, death of the control of the best of my knowledge, death of the control of the best of my knowledge, death of the control of the best of my knowledge, death of the control of the best of my knowledge, death of the best of my knowledge of the best of my knowled	stigation, in my opinion, death occurred a	t the time, date and p	lace, and due to the cause(s) and manner stated.
	To th withir To th comp	2	29b. Signature and title of certifier Madanus MP	29c. License number D039166	29d.	Date signed (Month, Day, Year)
) 1			Church N.			P. (201)
火	13+1		AWINS, MADARANG, MD 808 LAW 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Print) MARKDR. STE I	28 Glen	BUNKIND ZIVE!
	Stat Registra		31. Date filed (Month, Day, Year) OCT 18 2011 32. Aegistrar's Signature	all		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 10 Physician/ 6:15pM Betty Lou McCloud 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Oakland Nursing and Rehab Garrett Oakland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 9 8 1932 Hours Country) 217-28-9648 **Director** 1 □ M 2 🔀 F 79 "natural", or items 23a or 28a-f show dical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No MD Garrett Kitzmiller 10f. Zip Code 10g. Citizen of What Country? Funeral 255 E Main St 21538 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 X Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) homemaker own home other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F မ George William Stewart Gladys Lyons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sh ment of Health a ant: If item 27 is 2408 Alma Road, Baltimore, MD 21227 Larry J. McCloud-son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Department of Important: If i any injury or o I.O.O.F. Cemetery 10/29/2011 Elk Garden, WV Donation 5 Other (Specify) 22. Name and Address of Facility David A. Burdock Funeral Home PA Signature of Fu Service Licen 21 N 2nd St, Oakland, MD 21550 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and De Immediate Cause (Final P y i ian disease or condition resulting in death) Medical Due to (or as a consequence Lascy (ar Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury as the burial-trar and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 3 Ectopic pregnancy
5 Other (specify) ____ Month Day Pregnant at time of death signed by the a 1 ☐ Yes 2 2 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy page 2 certificate has performed 1 🗌 Yes 2 🗀 No Yes 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical examiner? 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural Accident Investigation Suicide 6 🗆 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Ceptifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Bucznski, M.D., 311 North Fourth Street, Suite I, Oakland, MD 21550

Registrar

State

31. Date filed (Month, Day, Year) **OCT 28 2011**

Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		1 - For Amend Item State Registrar	5 per fi	, g921',1'	1/0872 Cer	tificate of D	eath	id ivie	Re	g. No.2 C		35	140
Physicia Medic		Decedent's Name (First, Middle Lawrence Ray)		e				2	Date of Death		011	3. Time of 1800	f Death M
Examin		4a. Facility Name (if not institution,	give street and num	ber)		4b. City, Town, or	Location of D	Death		4c. Count	y of Deat	th	
Funeral		Garrett Co. Me	6. Sex	spital 7. Age (In yrs. Ia	ast hirthday)	Oakland If Under 1 Year	If Under 24	Hrs. 8	. Date of Birth	G	arre 9. Bir	thplace (State o	or Foreign
Director		5. Social Security Number 215-16-4707 -215-16-4709 Usual Residence of Decedent	1 ⊠ M 2□F	89	Yrs.	Months Days	Hours	Min.	(Month, Day, Year) C 08 25 1922			untry) MD	
show	'n	10a. State 10b. County		10c. City	y, Town or Lo	cation				10d. Inside Ci	ity Limits		
28a-f	Director	MD Garre	tt	Ki	tzmill								s 2 X No
3a or		10e. Street and Number PO Box 355				10f. Zip Code 21538			10	g. Citizen of	What Co	ountry?	
ems (Funeral	11. Marital Status		dent Ever in U.S		Vas Decedent of His				14. Ra	ce - Ame	erican Indian,	
", or if	þ	1 Never Married 2 Marr	If You Give	2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	.	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☒ No Specify:				Specif	ack, White v:		
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ental F ked o ic eve	To E	Leonard Moore	.ast/						Shimer	aluen Suman	ie)		
and M is mar		19a. Informant's Name/Relations	nip (Type, Print)		19b. Mailir	ng Address (Street a	and Number o	or Rural R	Route Number, (City or Town,	State, Zi	ip Code)	
lealth lealth sm 27 her tra		Debbie Gank-dan	ughter	Look D		Box 83,	E1k Ga		,		011	Town State	
age is ant of h t: If ite / or ot		1 Burial 2 Cremation 4 Donation 5 Other (S		State C	emetery, crer	sition (Name of natory or other place h Cemeter		Dat 0/20	/2011 2			en, WV	
permit. Page I and 2 should be lined within 72 hours after death with the maryland pagetrient of Health and Mental Hygiene. Important: If firem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service L		0		2. Name and Addres							me PA
an per		- Warned A	Durd	UCR		1 N 2nd S							
		23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final			h. Do not ente	er the mode of dying	g, such as car	ardiac or re	espiratory arres	t,		Approxima Interval Bet Onset and	tween
hysician/ Medical		disease or condition resulting in death)	a. Acut	te myoca oras <i>a</i> consequ	ardial	infarcti	on					1.5 ho	ur
Examiner	L	Sequentially list conditions,	h										
sit	Examiner	of Sequential is contained. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Cause (Disease or injury)											
executed an and rial-transi	Exal	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):											
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ding pt	/Med	IF FEMALE:	23c If yes out	come of pregna	incv					004.5) - A 6 I -	- live-e	
death certificate be he attending physici ed for use as the bu	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	he past 12 months? Yes 2 \(\subseteq \text{No} \) Yes 2 \(\subseteq \text{No} \) Other (specify)										Year
sidan: The law requires that the de- certificate has been signed by the rector, page 2 should be detached		Part II. Other significant condition	ons contributing to d	eath but not res	sulting in the u	underlying cause giv	ven in Part I.		23e. Did tob	acco use col	ntribute t	o the cause of	death?
n sign	ed by	Hip Fracti	ure two	days	prio	-			1 🗆 Ye	s 2 No	3 🗌 F	Probably 4 🗆	Unknown
as bee 2 shou	Completed			3					24a. Was an	y	prior to	utopsy findings completion of	
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riysician, me taw r this certificate has I aral director, page 2 s	Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	1	FD/0 1 -11:	Othe	ace of Death					- aif il	
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leath. or: After the funer	Certificate:	1	gation // D	24/2011	1600	M 1 □	Yes 2 N		Slipp		_		
al or An s after d I Direct d in by		4 Homicide determ	.: 28e. Place	of Injury - At hong, etc. (Specify	how	reet, factory, office		28	Bf. Location (Str City or Town,	State)	ber or Ric	× 355	ber,
To the Hospital of Attending within 24 hours after death. To the Funeral Director: After completed filled in by the funeral process.	Medical	(Check 2 Medical E	Physician: To the base Nurse Practioner:	sis of examinatio	ledge, death n and/or inves	occured at the time,	on, death occu	urred at th	due to the caus	e(s) and mar d place, and d	ner as si	tated. e cause(s) and m	ianner stated
vithin To the compl	2	29b. Signature	reges	a Depr	EXa	ed License	e number					th, Day, Year)	
	5	30. Name and address of person	who completed caus	se of death (Item	n 23a) (Type, I		2720	V 3		10/	~ 4	12011	
at	VA	KARL E.	SCHWAL			r. 4th <	St.	00	KLAN	D, N	17	2155	50
Sta Registra		31. Date filed (Month, Day, Year)	2011 7	Registrar's Signa	ture da	Med				•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Gary Everett McClintock 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WMHS Regional Medical Center Cumberland Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 170-36-4011 Director 1 X M 2 D F Yrs June 26, 1946 65 Pennsylvania Usual Residence of Dece or 28a-f show 10a. State 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No MD Garrett Grantsville 10e. Street and Numbe 10f. Zip Code 10a. Citizen of What Country? Funeral 1300 Pigs Ear Rd. 21536 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Heavy Equipment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) o Page 1 and 2 should be fi ment of Health and Menta Everett McClintock Mayalene Newcomer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 Sandra L. McClintock/Wife 1300 Pigs Ear Rd., Grantsville, MD injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Addison Cemetery Oct. 24, 2011 Addison, PA 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes, any P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or injury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of): physician Physician/Medical that the death certificate be as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Por in the past 12 months?

1 Yes 2 No Month Year Day detached 9 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ဂ 1 Inpatient 2 🗌 ER/Outpatient 3 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29c. License number SUDHEER SAN/KOMMU D 69737 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudheer Sanikommu, 12500 Willowbrook Rd., Cumberland, MD 21501

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

OCT 2 5 2011

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irma Ruth Medinger 201 Tear 2:00 a Dctober 13, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick Mt. Airy 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Months Days Min. 1 M 2 W F 72 306-38-7036 Indiana Director 1939l anuary Usual Residence of Decedent should be filed within 72 hours and and Mental Hygiene.
I see marked other than "natural", or items 23a or 28a-f show a marked other than "natural", or items 25a or 28a-f show are marked other than "hadical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Walkersville Frederick Maryland TXXYes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21793 35 Hampton Place Funeral USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedo... Armed Forces? → □ Yes 2 🔀 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 K No Specify: Completed Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 2 College (1-4 or 5+) Dental Office manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eliza Eldridge t. Page 1 and 2 should be friment of Health and Mentartant; If item 27 is marked jury or other traumatic en Raymond Smoot 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 Hampton Place, Walkersville, Maryland Charles Medinger - husband 21793 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or oth Date 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 10-18-2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 21. Sign were of Funeral Service Licensee Stauffer Funeral Home 22. Name and Address of Facility 1621 Opossumtown Pike, Frederick, Maryland 21702 game 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 40 b disease or condition RAK Medical resulting in death) Examiner Sequentially list conditions, if any, reading to introduct cause. Enter Underlying Due to (or se a consecuence of, Exami death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the s Unknown P.O. I To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed Yes 2 1 🗆 Yes 2 🗆 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence Hospice House 2 No 1 🗌 Yes 욘 ER/Outpatient 3 DOA 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? injury 1 Natural Accident 5 Pending 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 □ only one 29b. Signature and title of certifier

State Registrar

8

arke

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Sadaf Taimur, M.D.

31. Date filed (Month, Day, Year)

29c. License number

46B Thomas Johnson Drive, Frederick, Maryland

29d. Date signed (Month, Day, Year)

21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day MERRIS NAN 2011 Medical Ca 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death **Examiner** 4c. County of Death 9. Birthplace (State or Foreign Country) Pennsylvania Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Month, Day, 2/28/ Days Min 71 Yrs. **Director** 36-1939 6450 Usual Residence of Decedent 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 619 Meyersdale Road 21536 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 X No Specify Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Charles Handlin Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David L. Merrbach/ Husband 619 Meyersdale RD., Grantsville, MD 21536 Baltimore, 20b. Place of Disposition (Name of Merripa ChatorFoath 1 129 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Cemetery 4 Donation 5 Other (Specify) 10/9/2011 Grantsville, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes P.A. 179 Miller St., Grantsville, MD 21536 23a. Part 1. Enter the disease, or complicatio shat the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical onsequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ysician and burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Physician/Medical Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Į Month Day Year Pregnant at time of death n signed by the a ld be detached for 9 Unknowi P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law cate has page 2 s autopsy performed death? certificate 2 🗀 No 1 Yes Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DQA this Residence 6 Other (Specify funeral 27. Mann of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Tes 2 🗌 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Mont) em 23a) (Type, Print) State 13 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ October Barbara Ann McGrath 1:40 P Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ellicott City Howard 9728 Cypressmede Drive 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 107-32-5663 Director 1 🗆 M 2 🖵 F June 8, 1941 New York Yrs. 70 Usual Residence of Deceden or 28a-f show notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Howard Ellicott City 1 Yes 2X No MD 10f. Zip Code 10g, Citizen of What Country? 10e Street and Number ō and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be i Funeral United States 21042 9728 Cypressmede Drive death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married Married Yes 2 No þ Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse St. Agnes Hospital Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, 2 Corridan permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic. once, Bernard J. Leddy Marv 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Emile R. Mohler, Jr./husband 9728 Cypressmede Drive Ellicott City, MD 21042 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/24/2011 | Ellicott City, MD John's Cemetery Signature of Funeral Service I 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City, MD 21043 tromas 23a. Part VEnter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of, the burial-transit Due to (or as a consequence of): attending physician Physician/Medical certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Fctopic pregnancy in the past 12 month Day Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy has page 2 Yes 2 No this certificate I or Attending Physician: after death.

Director: After this certifications filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 5 \square Pending work?
1 Yes 2 No Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Octuber 21,2011 044243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Road Cathorille MO ZIZZE N. Kollin

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month) (Pay) Year)

Unpend 23a, 27, 28a-f.per Maj, USAF, MC, Military, g922 12-28-11 sm Please Type or Print in Black Indelible link. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2 0 35 45														
			Negistrar Decedent's Name (First, Middle,	Last)				imouto o	, , , ,		2. Date of De	ath	<u> </u>	or I	3. Time of E	
	Physicia Medic				DAVID	MILI	ER, J				OCT 1	1	11		1:50	P M
	Examin	er	4a. Facility Name (if not institution, WRNMMC	give street an	nd number)			4b. City, Tow	n, or Locat HESDA	ion of Death		4c.	MONT		יעסי <i>י</i>	
	Funeral			6. Sex		(In yrs. las	t birthday)	If Under 1 Y		nder 24 Hrs.	8. Date of Bir	th V Year)	9.	. Birthpla	ace (State or	Foreign
	Director		155 90 6872 Usual Residence of Decedent	1 XX 2	L F	23	Yrs.	IVIOITIIS D	lys Hou	IS IVIIII.	Sept 23	<u>, 198</u>	8	New	Jersey	
	and show 1 at	ō	10a. State 10b. County			10c. City,	Town or Loc	cation						100	d. Inside City	
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	ith the 23a or it be n	ralD	10e. Street and Number		П			10f. Zip Co					izen of Wha			
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36	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er tha Medical Examiner must be notified at the Medical Examiner must be notified at	by	1 Never Married 2 Marri	ed 1 🗓	ned Forces? Yes 2 □ Nes, Give r or DatesAC	No		f Yes, specify (I ☐ Yes 2 🙀			nicari, etc.)		Black, V Specify:	White, etc		
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lary	should and N is ma		19a. Informant's Name/Relationsh								al Route Numbe		Town, State	e, Zip Co	ide)	
e,	and 2 Health tem 27		Theresa L. Wilson (Mother)	<u>-</u>	20b. Pla		Kingslan sition (Name o		_	<u>yn NY 112</u> Date		ocation - Cit	tv or Tow	vn, State	
mor	- 5 :- 0		1 🎇 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		al from State	cer	netery, cren	natory or other	place)				n <u>eton</u> .			
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once,		4 Donation 5 Other (Specify) 21. Signs ure of Funeral Service Licensee Arlington National Cemeteric (unk) 22. Name and Address of Facility Lee Fun											-		andria
m	90 = 9		23a. Pag 1. Enter the disease, or	d, Cli	nton M	20735				Approximate						
and the	Physician/		shock, or heart failure. List o Immediate Cause (Final	nly one cause	e on each line.						, , , , , , , , , , , , , , , , , , ,	,			Interval Betv Onset and D	ween
	Medical		disease or condition resulting in death)	_ d	Oue to (or as a			und to	the i	iead						
	Examiner	Į.	Sequentially list conditions,	b. —												
	red nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury		ue to (or as a	Conseque	nice oi).							-		
	execut an and rial-tra	l Exa	that initiated events resulting in death) Last	c	Due to (or as a	conseque	nce of):									
09	cate be executed physician and s the burial-transit	edical		d						_						
687	ath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		es, outcome o								23d. Date of	of deliver	ry	
Box 68760	death of atter	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 🗆	☐ Live Birth 2 ☐ Pregnant at ☐ Unknown			☐ Ectopic preg ☐ Other (special					Month	n [Day Y	/ear
P.0.	requires that the de been signed by the should be detached		9 Unknown Part II. Other significant condition			ut not resul	ting in the u	underlying caus	e given in	Part I.	23e. Did	tobacco i	use contribu	ute to the	e cause of de	eath?
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ord	w requests peers	Completed									24a. Was		24b. We	re autop:	sy findings a	available ause of
Be	hysician: The law his certificate has I director, page 2 a	Com										ormed?		ath? Yes 2	2 🔀 No	
lita	sician, certifi irector	o Be	25. Was case referred to medical examiner? 1 X Yes 2 □ No	Hospital	X Innatio	unt o \square E	IP/Outpation	2 nt 3 🗆 DOA	Othor:	Death (Chec	k only one) ome 5 \square Res	idanaa 6	Other /	(Spaciful		
of	ig Phy ter this neral d	te: To	27. Manner of Death		Date of injur (Month, Day,	у 2	28b. Time of injury	f 28c.	Injury at work?		28d. Describe	how injur	y occurred			
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Division of Vital Records,	after of Direct of in by		4 🗌 Homicide determ	ned 28e.	building, etc.			eet, factory, of	ice		City or To	wn, State	2)			
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying (Check 2 Medical E	Physician: To xaminer: On:	o the best of r	mv knowle	dge, death	occured at the	time, date	and place, ar	nd due to the c	ause(s) ar	nd manner a	as stated	d.	
	the Fithin 24 the Formplet	Me	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Pract	ioner: To the t	best of my l	knowledge,	death occurred	at the time	, date and plac	ce, and due to t	he cause(s) and mannate signed (f	ner as sta	ited.	
~	F 3 F 8		1 Janie	7,004	MD					194 (1	NC)		CT 1			
100	To a		30. Name and address of person	vho complete	ed cause of de		23a) (Type, F				MEDICAL	EXA	MINER	S		
			TERRILL TOPS 31. Date filed (Month, Day, Year)		MC USA	AF ĸ's Signatu	10	141	3 RES	SEARCH	BLVD.,	ROC	KV ILL	E MD	2085	0
	Stat Registra		NOV 0 3	2011	alkens	- 1	. 100	erland								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 14. 13:30P M 2011 Stanley Leo Phebus October 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Carroll Westminster 1680 Linzze Drive Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Social Security Number 7. Age (In yrs. last birthday) Sept. 21, Hours Maryland 1 XM 2 F 64 194 213-46-2276 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2X No Maryland | Howard Woodbine 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21797 2942 Florence Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 X Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Driver Truck 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Virginia Harggett Dudley Leo Phebus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 21797 Larry S. Phebus - Brother 2942 Florence Road, Woodbine, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Jennings Chapel Cem. 10/19/11 Woodbine, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fune | Service Licenses 22. Name and Address of Facility
Molesworth-Williams P.A., F
26401 Ridge Road, Damascus Funeral Home 20872 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical Examiner

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine and for use as the burial-trar that initiated events resulting in death) Last cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but

State Registrar

10a. State

Director

Completed by Funeral

Be

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Physician/

Medical

Examiner

Funeral

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

My ocard. Due to (or as a consequence of): (as amoun Due to (or as a consequence of Dicheres Due to (or as a consequence of):

IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕊 Unknown perphenal vascular disene 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Noth Richards home 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred

Completed by Be 25. Was case referred to medical examiner? ပ္

27. Manner of Death Certificate: X Natural

(Check

only one)

Accident
Suicide

5 Pending Investigation 6 Could not be determined

28b. Time of

28c. Injury at work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature apartitle of certifier

MA

29c. License number D 55104

October 17, 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gail T. Griffin, M.D. 31. Date filed (Month,

CI 18

1502 South Main Street, Mount Airy, Maryland

State Registrar

h

Medical

within 24 P

> State Registrar

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

30 Name and addre 1604 MARKET ST- POLOMUKE CITY MD JATYM, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year)

29c. License number

0 62172

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2ÖÎ'1 0113 Miriam Jensen Paris Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 129 West Thomson Drive Elkton Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** AUG 12, 1927 Country) Maryland 1 🗆 M 2 🗓 F Months Days Hours 214-22-7165 84 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State death with the Maryland Director 1 Yes 2 X No E1kton Maryland Ceci1 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 129 West Thomson Drive 21921 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify 3 🕅 Widowed 4 🗌 Divorced White traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Department of Elementary/Seconday (0-12) College (1-4 or 5+) Social Services Secretary 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola I. Boulden Thomas L. Jensen 1 and 2 should be the Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 145 Linton Run Road, Port Deposit, MD Amber Linton/Daughter permit. Page 1 and 2 Department of Health Important: If item 27 any inJury or other tu 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 28 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Elkton, MD Elkton Cemetery 22. Name and Address of Facility licks Home for Funerals, F.A. 21. Signatur of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition NEUMONIA Physician Medical resulting in death) Due to (or as a consequence of): Examiner -NUTRI Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last and -tran burialattending physician for use as the buria Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Live Birth 2 Tetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Pregnant at time of death 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ BRONCHITIS 1 Yes 2 No 3 Probably 4 Unknown cate has been sig Completed DECONDITIONING 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? SFUNCTION performed AMBULATORY 1 Yes 2 No certificate To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, t 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \swarrow Residence 6 \square Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar RUGERS RD #211 YORTH EAST MD21901

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death <u>Reg.</u> No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 10nth 1 6 2011 Physician/ 6:30A M Miriam Huffer Rice Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Frederick Golden Living Center 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth County **Funeral** Months Hours Marth 22779 913 218-50-3132 97 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State Director Frederick Middletown MD1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number items 23a Funeral 21769 within 72 hours after death with 6322 Old Middletown Rd. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? Black, White, etc. P. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White "natural" Completed 3 X Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary L. Ahalt Arthur H. Huffer ddress (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21769 Old Middletown Rd., Middletown, MD 19a. Informant's Name/Relationship (Type, Print) Connie Kinna (Daughter) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 XBuria 2 Cremation 3 ARemoval from State Lutheran Cemetery 10/20/2011 Middletown, MD 5 Other (Specify 4 Donation ignature of Fun vall ervide Licen ²²Dona and Address of Facility ompson Funeral Home POB 18. Middletown. art 1. Enter the disease, or complications that coused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock or heart failure. List only one cause couse Approximate Interval Between Onset and Death Immediate Cause (Final Colormy & SCLEROSIS Anteny ATHER Priysician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2 sompleted filled in by the funeral director, page 2 seconglished. autopsy yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 X No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of De 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suich Certificate: 5 Pending Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion death. Medical 29a. Certifier 2 In Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License numbe 30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

>IBTE

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

KAZMI, MO

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HOUSE AUE -

FREDERICK

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Russell Mildred Dorothula Medical 20 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Cumberland Allegany Western MD Regional Medical Center Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 Days Hours Min. 93 Director 215-20-6368 Virginia 02/11/1918 Usual Residence of Deceden permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director LaVale 1 Yes 2 X No Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21502 1 Glenview Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5 Elementary/Seconday (0-12) Public Schools Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Arnold Osborne Anna Pauline William Clarence 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Cathy A. Blank / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State Cumberland Crematory 10/12/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Rome, P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death ERE BR Physician. disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

Registrar

State

only one

29b. Signature and title of certifier

1221-E National Highway, LaVale, MD Shiv C. Khanna, M.D., 31. Date filed (Month, Day, Year) OCT 12 2011 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Darks

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

21502

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death [™]Oct 8, 2011 Physician/ 0025 Roach Ronald Medical 4c. County of Death 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death Examiner Allegany Cumberland Allegany Health Nurs. & Rehab. Ctr. 9. Birthplace (State or Foreign Country) ME If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth **Funeral** Yul 31 214-42-0391 66 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland Director Cumberland MD Allegany 1 XYes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral 21502 USA 40 Humbird Street 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: white Vietnam 3 Widowed 4 Divorced th and Mental Hygiene.
77 is marked other than "natur traumatic event, the Medical." 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Overnite Transportation Co. truck driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any liviny or other traumatic eve anse. ၉ Eleanor F. Neary Floyd A. Roach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 40 Humbird Street Cumberland 19a. Informant's Name/Relationship (Type, Print) ິ MD 21502 Cynthia Roach wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 10/11/20 MD Restlawn Memorial Garden's LaVale 4 Denation 5 Othe (Specify) 21. Sig 22. Name and Address of Full Eral Home, PA Funeral Servid Licensee 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Physician. disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death ed by the detached 9 Linknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ြို this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No 5 Pending 1 Natural
2 Accident
3 Suicide Natural Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TH 30. Name and address of person who completed cause of death (them 23a) (Type, Print) Barreray m.D. 200 Glenn St. Ste. 300 Cumberland, MD 21502 Robustianou.

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State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMELY 67 4468 601 PAHEIN CN DENTON, MO 21620	7	14			ted cause of death (Item	1 23a) (Type, F	Print)	DENTON	MO	2/67	7			
State Registrar St. Natifie and address of person with Sompleted datase of death (tell 20) (type, thin) AMERICAN GOLDAND LN DENTON, MO 21620 State Registrar OCT 18 2011 Server D. Spark				31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	had I		, , , ,	- 1 2 4				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10th 12 - 20112359 Wallace W. Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1113 Jefferson Talbot Ave. St. Michaels 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Hours Min 3-24-1940 219-36-5343 71 Md. **Director** Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertall Hygiene. It are the file may 1 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director Md. Talbot St. Michaels 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1113 Jefferson 21663 Ave. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces to Black, White, etc. 1 Never Married 2 Married ģ 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assistant Manager Food Store Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Robinson н. Willey Lenora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bette Rose Robinson / Wife 1113 Jefferson Ave. St. Michaels, Md. 21663 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Olivet Cemetery 20c. Location - City or Town, State Department of Important: If it any injury or o ooce. 10-17-2011 St. Michaels, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Hurley & Ostrowski Funeral Home P.A. P.O. Box 518 St. Michaels, Md. 21663 1st 12003/5' 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death 2 urs 7 mm Physician/ COLON CANCER disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant at time of death detached the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed d be det þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 XNO 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral directors. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 1 Yes 2 No Accident Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10-17-2011 ACOOO 387 125

State Registrar

DHMH 17 Rev 7/2009

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

8221 TEAL DRIVE

EASTON, MD 21601

erson who completed cause of death (Item 23a) (Type, Print)

. Registrar's Sigr

ANP-C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:08 AM Blaine 0 Medical Facility Name (if not institution, give street and number) County of Death **Examiner** ounty Memorial Tarret aklanc 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Min West Virginia Director show and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It among a same as 28a or 28a-f show then 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD Garrett McHenry 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral PO Box 223 Springwood Acres 21541 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur
any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 12 Homemaker Housework Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnston Melvin Blaine Foley Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, James Rodney/husband PO Box 223 Srpingwood Acres, McHenry, MD 21541 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Cumberland Crematory 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Cumberland Maryland 10/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Boal Funeral Home 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final ∉nysician/ disease or condition resulting in death) Medical Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of Exami that the death certificate be executed and bunial-trar that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Division of Vital Records, Hospital or Attending Physician; The law requires 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autop-performe 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 မှ 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of co 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month Lay, lear

Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Robert Goralski, 311 N. Fourth St, Oakland, MD 21550

32. Bajistrar's Signature

D 23979

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ october 5, 2011 1:25A M Eleanor Virginia Renn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Heritage Center If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In vrs. last birthday Months Hours West Virginia 1 M 2 X F 9 18 7 1 9 1 3 Director <u>233-66-7364</u> an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 12103 Tullamore Ct. #401 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 😾 Widowed 4 🗆 Divorced Specify: White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Homemaker Home 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Mary Virginia Bosley Grant Bosley Newton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a 12103 Tullamore Ct.#401, Timonium, MD21093 Isabelle Tustin/Daughter item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State Alkire Cemetery 10/8/2011 Mt. Storm, WV 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 203 S. Second St., Oakland, MD 21550 23a. Part 1. Enter the disease, or complications that a death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗌 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Decritifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

State Registrar Name and address of p

1 3 2011

DHMH 17 Rev 7/2009

place

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Oct 3, Physician/ 2011 7:55 AM Winifred Steiner Marv Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 109 N. Chase Street Allegany Cumberland 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 □ F ^{Yea} 1925 Months Hours Feb 2. Director 217-42-6278 86 Usual Residence of Decedent important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 109 N. Chase Street 21502 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black, White, etc. should be filed within 72 hours after d and Mental Hygiene. is marked other than "natural", or i ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 XWidowed 4 Divorced white Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Nurse Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) 0 Bertha Hammers Patrick H. Griffin permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 714 Nemacolin Avenue LaVale John Steiner 714 Nemacolin Avenue MD 21502 son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Townstion 3 Removal from State
4 Donation 5 Other (Specify) Scarpelli Funeral Home, P.A. 10/4/201 MD Cresaptown Funeral Ser 22. Name and Address of Facility Parent Home, PA Signature 108 Virginia Avenue: Cumberland, MD 21502 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death shop Immediate Cause (Final Physician/ deno carcinon Stoma disease or condition 1ces Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Box 68760 IF FEMALE ase 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy atter for u in the past 12 months? Day Month Year 5 Other (specify) Pregnant at time of death ☐ Yes ∠∟ ☐ Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X-NO မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 4 hours after death. uneral Director: After ed filled in by the fun Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a Certifier 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 42054 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 912 Seton Drive Cumberland, MD 21502 nes Donaldson 32. Registrar's Signature

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Registrar

2011

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #12 Per FH G922 12/08/2011 entrol Health and Mental Hygiene

		•	1 - State Registrar			Cert	ificate of L	Death		Re	_{.g. No.} 20		351	5 1
	Physicia	n/	1. Decedent's Name (First, Middle,	,			.			e of Death		1 Year	3. Time of Dea	
	Medic		Jess Joseph Smi							10/	147201	1.00	715	ам
	Examin	er	4a. Facility Name (if not institution, 2567 Golfers Ri				4b. City, Town, or				4c. County	of Death	do1	
9.4	Funeral				(In yrs. last birt	hday)	If Under 1 Year	apolis		e of Birth	Aillie		lace (State or Fo	oreign
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	or 28	Dir	10e. Street and Number				10f. Zip Code			10	Og. Citizen of V	What Coun	try?	
	with t	Funeral Director	2567 Golfers Ri	dge Rd.			21	401		- 1	-	SA		
	death items		11. Marital Status	12. Was Decedent E	ver in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	ispanic Origi	n? (Specify Yes Puerto Rican, e	or No-		e - Americ		
36	after al", or xamii	d by	1 ☐ Never Married 2★★Marri 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 1	57- 62	1	☐ Yes 2 KKNo		,	,	Specify:	TA	hite	
9	hours natura lical E	Completed	15. Decedent		16a.	Decede	ent's Usual Occup	ation		1	16b. Kind of B	usiness Ind	dustry	
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Baltimore, Maryland 21215-0036	be file ental F ked o c eve	To E	17. Father's Name (First, Middle, La Jess Smith	Sty					's Name (First, Cokende			9)		
az	nd Me		19a. Informant's Name/Relationshi	p (Type, Print)	19b	. Mailing	Address (Street a					State, Zip C	Code)	
Ξ̈́	d 2 shalth a		Maenette Smith	Wife	1	_	Golfers			-			•	
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 KkCremation	3 Pamoval from State	20b. Place of cemeter	Disposi	ition (Name of atory or other plac	ce)	Date	2	20c. Location -	City or To	wn, State	
Ĕ	Page tment tant; jury o		4 Donation 5 Other (Sp	pecify)		ic (Cremator	у 1	10/18/2					
Baj	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li	ensee		107	Name and Addres			_			P.A.	
			23a. Part 1. Enter the disease, or o	complications that caused	the death. Do n		Ridgely the mode of dying					401	Approximate	_
.9%.	Ph _{sician/}	0	shock, or heart failure. List or Immediate Cause (Final	ly one cause on exh line.	. 1	1	. /	1	Scle		-		Interval Betwee Onset and Deat	th
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Box 6	attendir for use	Physician/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	2 🗌 Fetal death		Ectopic pregnance Other (specify)	у			23d. Da	te of delive	ery Day Year	r
ĕ.	the a	ysic	1 Yes 2 No 9 Unknown	4 ☐ Pregna <i>n</i> t at 9 ☐ Unknown	time or death	5 🗆	Other (specify)							
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בֿ	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director. After this certificate I completed filled in by the funeral director, page		00-0-15 1 50	Physician: To the best of n		Ab		d-4 1-1						
	e Hos 124 hc e Fun	Medical	(Check 2 Medical Ex	aminer: On the best of haminer: On the basis of ex Nurse Practioner: To the b	amination and/o	r investig	jation, in my opinic	on, death occ	urred at the time	e, date and	place, and due	e to the car	use(s) and manne	r stated.
	vithir Voithir Comp	2	29b. Signature and title of certifier	1,			29c. License				d. Date signed			
	,		1 Jank Su	hetz			103	3584	18		101	114/	11	
	8,0		30. Name and address of person w	no completed cause of de	ath (Item 23a) (1	1/	G	embr,	11.	la. 1 2	LIDS	4	
	l0 Stat	e	31. Date filed (Month, Day, Year)	CNn //Z /7 32/Registrar	's Signature	Jen	nse My	- 4	m Dr1	15		. 03		
	Registra		OCT 182	111 /2	4	1.	111							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For AMEND#20b per State 10/26/2011 AMEND#20b per Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/13/2011 Year 1325 Susan J. Smithson Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AAMC Anne Arundel Annapolis 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav) 8 Date of Birth **Funeral** Min 1 ☐ M 2413 F Days th, Day, Year) 219-36-9003 Yrs Director 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Annapolis 1 Yes XX No 10e. Street and Numbe 10g. Citizen of What Country? ò 10f. Zip Code er than "natural", or items 23a or the Medical Examiner must be Funeral 2513 Bollard Rd. 21401 USA death \ 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XXIII Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify. White Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 2 should be filed with h and Mental Hygien. 7 is marked other th RN Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ other traumatic John Paul Smith Susan DuVall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Frederick Smithson 2513 Bollard Rd. Annapolis, MD 21401 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date UNK 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 12/5/2011 Arlington, VA Arlington National 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Immediate Cause (Final and Dear Ph sician/ disease or condition Medical resulting in death) (or as a consequence of **Examiner** neumonia Sequentially list conditions if any, reading to immediate cause. Enter Underlying Due to for as a consequence of, Examir executed Cause (Disease or linjury that initiated events and -tran resulting in death) Last Due to (or as a consequence of) nding physician a Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE asn 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown P Month Year Pregnant at time of death the g Unknown ed by the signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 1 🗌 Yes 2 No Yes 25. Was case referred to medical Be filled in by the funeral director 26. Place of Death (Check only one) Hospital 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes မှ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title person who completed cause of death (Item 23a) (Type, Print) Pefense Huy, Crofton, MD 21114 VID 2225E Date filed (Month, Dav. Year. 32. Registrar's Signature State

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Registrar

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Examin		4a. Facility Name (if not institution, gives Casey House Hospi		·	4b.		Location of Death		4	c. County of De	
Funeral Director		5. Social Security Number 6. Sex 577–16–6645	7. Age (I	n yrs. last birti 98		Under 1 Year nths Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)		Birthplace (State or Foreign Country)
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or 28a-f notified	Director	Maryland Montgom 10e. Street and Number	nery	S		Spring	g 		10g C	itizen of What	1 ☐ Yes 2 🗷 No
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permit rager and 2 should be the whilm 12 hours after death with the maryland bondardent if it health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.		If Yes,		spanic Origin? (Sp. n, Mexican, Puerto Specify:			14. Race - Ar Black, Wl Specify:	merican Indian, hite, etc. White
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Impor any in		21. Signature of Funeral Service Licenser			22. Nan	ne and Address Muriel P. O.	s of Facility H. Barbe Box 5038	er Fune , Layt	ral onsv	Home ille, N	MD. 20882
nysician/ Medical xaminer		23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	ovascu	lar A	mode of dying		or respiratory a	rrest,		Approxi <i>m</i> ate Interval Between Onset and Death
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within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	~	IF FEMALE; 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of p 1 Live Birth 2 4 Pregnant at tir 9 Unknown	Fetal death		opic pregnancy er (specify)	/		23d. Date of delivery Month Day		
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ath. nr: After this he funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Ye	28b. Ti		28c. Injury work?	at	28d. Describe			ecity)
rs after de al Directo ed in by t	O	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S		m, street, fa	ctory, office		28f. Location (City or To			Rural Route Number,
in 24 hou he Funer pletely fill	Medical		eian: To the best of my er: On the basis of exam Practitioner: To the be	nination and/or	investigation	n, in my opinior	n, death occurred at	the time, date	and place	e, and due to th	e cause(s) and manner state
with To the com	— r	29b. Signature and title of certifier —	niller	CR	NP	29c. License	number 43201		29d. Da	ate signed (Mor	nth, Day, Year)
5		30. Name and address of person who cor Debrah Miller, CRI				4 i 11 Ro	ad, Rock	ville,	MD	20855	

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	1 - State Amend Item 25 per me,	$\frac{\text{anyland}}{\text{g925}}$	9/2012dhb ertificate of D	lealth and M Death	1ental Hyg	iene	35160
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	C	MITH		2. Date of Deat	h Day Year	3. Time of Death 9:30 P _M
go e L	Examin		4a. Facility Name (if not institution, give street and number) The Johns Hopkins H	ospital	Balt.	MUTC C	sity	4c. County of Death	
	Funeral Director		5. Social Security Number 216-22-7853 6. Sex 7. Agr	e (In yrs. last birthday) 81 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, February	Year) Cou	hplace (State or Foreign Intry) Maryland
	faryland Ba-f show tified at	Director	10a. State 10b. County Maryland Howard	10c. City, Town or Le					10d. Inside City Limits 1 ☐ Yes 2 🖾 No
	with the Ns 23a or 2 ust be no	Funeral Di	10e. Street and Number 2806 Foxhound Road		10f. Zip Code 214	02		10g. Citizen of What Co USA	untry?
9036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Namried 1 Never Namrie		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🛣 No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amei Black, White Specify: W	
21215-0036	nin 72 hou ne. han "natu e Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5	(Give	edent's Usual Occup e kind of work done o DO NOT use retired)		ing	16b. Kind of Business/ Education	
and 21	2 should be filed within 7 h and Mental Hygiene. 7 is marked other than traumatic event, the M	To Be C	5+ 17. Father's Name (First, Middle, Last) Eugene Bradley Smith	rrinc	Трат	18. Mother's Nam Freda Na		Maiden Surname)	
	12 should tall than the strain of the should the strain of	33	19a. Informant's Name/Relationship (Type, Print) Lorna Smith — wife	19b. Mai 280	ling Address (Street a	and Number or Rura	al Route Number.	City or Town, State, Zip	71and 21402
Baltimore,	Page nent c ant: If iry or		20a. Method of Disposition 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	20b. Place of Disp cemetery, cre Maryin Ch	position (Name of ematory or other place apel Ceme	e)	Date 20-2011	20c. Location - City or Mt. Airy,	
Balti	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	line 1		umtown Pi	ike, Fre	Funeral Horderick, Mar	ne ryland 21702
L	Physician/ Medical			d the death. Do not ene. hereing a consequence f):	iter the mode of dyin	g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner list	Examiner	cause. Enter Underlying Cause (Disease or injury	a consequence on.		ERTIFICATION APPAR	A by MEDICAL	EXAMINER	
09	ate be executed bhysician and the burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (or as	a consequence of):	0	ERTIFICATION APPRI)		
Box 687	ith certifica tittending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	☐ Ectopic pregnand	sy .		23d. Date of de Month	livery Day Year
s, P.O.	requires that the dea been signed by the a should be detached		Part II. Other significant conditions contributing to death be	out not resulting in the	underlying cause given	ven in Part I.		obacco use contribute to Yes 2 🏂 No 3 □ F	the cause of death?
Records,	The law requate has beer page 2 shou	Completed by					24a. Was a autop perfor	prior to death?	ntopsy findings available completion of cause of
of Vital	sician: The la certificate ha lirector, page	To Be (25. Was case referred to medical examiner? 1 X Yes Hospital: Hospital: 1 X Input	ient 2 🗆 ER/Outpati	LOth	ace of Death (Chec		lence 6 Other (Spec	nify)
on of V	nding Phys ath. :: After this ie funeral di		27. Manner of Death 1 Natural 5 Pending (Month, Da 2 Accident Investigation	ury 28b. Time	of 28c. Injur work	y at		ow injury occurred	
Division	al or Attending P s after death. Il Director: After t' ed in by the funera	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Inj building, et	iury - At home, farm, s cc. (Specify)	treet, factory, office		28f. Location (S City or Tow	street and Number or Run, State)	ıral Route Number,
_	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier (Check only one) 1. Certifying Physician: To the best of the desired Physician (Check only one) 1. Certifying Physician: To the best of the desired Physician (Check only one) 2. Medical Examiner: On the best of the desired Physician (Check only one) 3. Certifying Nurse Practitioner: To the best of the desired Physician (Check only one)	examination and/or inve	estigation, in my opini- ge, death occurred at	on, death occurred a the time, date and p	at the time, date a lace, and due to t	nd place, and due to the he cause(s) and manner a	cause(s) and manner stated. as stated.
	To the within 7 To the Comple		29b. Signature and title of certifier	nD	29c. Licens	e number - 000		29d. Date signed (Mont	h, Day, Year) 14, 2011
	8		30. Name and address of person who completed cause of cliffony M. Frazel, MD	leath (Item 23a) (Type 600 N.	Print) Wolfe Str	eet, Balt	imore,	Maryland 2	21287
	Sta Registr		31. Date filed (Montk, Day, Year) 32. Registr	rar's Signature	barkes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 12:40p 2011 October Norma J. Sullivan Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner <u>Frederick</u> Middletown 5 Layla Drive 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** 1 □ M 2 🖾 F Months Davs Hours Min Sept 8, 1945 Marÿlty)nd 220-42-3733 Yrs Director 66 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Middletown Maryland Frederick 20 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21769 USA 5 Layla Drive than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 FNo If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2XXMarried ģ white 1 ☐ Yes 2X No Specify: 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Circulation manager and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha Everhart I and 2 should be fill Health and Mental Item 27 is marked ည Frederick Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 5 Layla Drive, Middletown, Maryland Gary Sullivan - husband tem 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition permit, Page 1 a Department of H Important: If ite any injury or ott 1 Burial 2 Cremation 3 Removal from State 10-15-2011 Frederick, Maryland Resthaven Memorial 4 Donation 5 Other (Specify) 22. Name and Address of Facility ture of Funeral Service Licensee Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onset and Death Pulmana v Immediate Cause (Final disease or condition Physician/ Raw. Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): burial-transi Due to (or as a consequence of): attending physician Physician/Medical certificate be the IF FEMALE: yes, outcome of pregnancy Live Birth 2 Fetal death 3 Ectopic pregnancy Prognant at time of death 5 Other (specify) 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After the Certificate: 1 Natural Pending work? 1 Yes 2 No Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical of tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

0

within 2

only one

31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records.

DHMH 17 Rev 7/2009

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Maryland		rtment of Hea				0=160
			Registrar 1. Decedent's Name (First, Middle, Last)				2. Date of Death	No. 2011	3. Time of Death
	Physicia /Medic		Maria Schne	,de			Month	Day Year ≥7 20(1	0715 AM
	Examin		4a. Facility Name (If not institution, give street and number) CALVERT MEM. HOSPITAL		4b. City, Town, or Local PRINCE	ation of Death FREDER	ICK	4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. le	a <i>st birthd</i> ay) Yrs.		Under 24 Hrs. lours Min.	8. Date of Birth	9. Birth	place (State or Foreign LAND
	pui »		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryla f shov	ō	MD. CHARLES		HUGHESVIL	LE			1 □Yes 2X No
	with the I a or 28a- be notif	Director	10e. Street and Number 7070 COLONIAL LANE		10f. Zip Code 2063	7	"	p. Citizen of What Cou	intry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventaine must be inciffied at ance.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:	'	Was Decedent of Hispar f Yes, specify Cuban, M	nic Origin? (Spe	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White, Specify: WHI	etc.
Maryland 21215-0036	nin 72 hour s. in "natural Nedical E	Completed b	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give life, L	dent's Usual Occupation kind of work done during OO NOT use retired)	ng most of workir	ng	6b. Kind of Business/li	
2	ed with ygiene ier tha t, the	Com	12th	PER	SONNEL BA			IARBOR FE	D. BANK
land	uld be filk Mental H rked oth rtic even	To Be	17. Father's Name (First, Middle, Last) RODGER O KANE		1 1 1		(First, Middle, Ma ROSE RO		
	nd 2 sho alth and I 27 is ma r trauma		19a, Informant's Name/Relationship (Type. Print) KATHLEEN EDNIE-DAUGHTER		ng Address (Street and COLONIAL		HUGHES	City or Town, State, Z	ip Code) 0. 20637
altimore,	Pages 1 ar nent of Hea ant: If item ury or othe		11 I Burial 2 M Cremation 31 I Hemoval from State 1		sition (Name of natory or other place)			Oc. Location - City or T	
Baltin	permit. P Departme mportan tny Injury		4 □ Donation 5 □ Other (Specify) METROP(21. Signature of Funeral Service Licensee MO 0 4 7 9		N CREMATO Name and Address of RAYMOND F LA PLATA,	Facility UNERAL	SERVIC	E,P.A.	
	EU = 60		23a. Part1. Enter the disease, or complications that caused the death	Do not ent	LA PLATA, er the mode of dving, si	MARYLA	ND 2064 or respiratory arres	5 6	Approximate
	Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	L _	Luc Co.	(5) -			Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of the consequen	ence of):	and the				92.73
	led sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ence of):					1
30,	ficate be executed physician and s the burial-transit	Il Examiner	that initiated events resulting in death) Last C Due to (or as a consequ	ence of):					
58760,	ficate I physics the b	dical	d			* 7			
P.O. Box (The law requires that the death certific ale has been signed by the attending p age 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 风 No 9 □ Unknown 23c. If yes, outcome of pregnant 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of do 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
	w requires that s been signed by should be deta	þ	Part II. Other significant conditions contributing to death but not resu	Ilting in the u	nderlying cause given in	n Part I.		acco use contribute to	the cause of death? obably 4 \times Unknown
al Records,	: The law req cate has beer page 2 shou	Completed					24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of 2 ☐ No
Vita	siclan: The certificate irector, page	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐	FB/0t+:	Othor		(Check only one)		
O	g Phy er this	n: To	27. Manner of Death 28a. Date of Injury	28b. Time of Injury	IL 3 LI DOA		me 5 Residen 28d. Describe how	ice 6 Other (Special of the first occurred)	city)
Division of	To the Hospital or Attending Physician: within 42 hours after death. Of the Funeral Director: To the Completely filled in by the funeral director; completely filled in by the funeral director; p.	Certification:	1 ★ Natural 5 Pending (Month, Day, Year) 2 Accident investigation 3 Suicide 6 Could not be determined 4 Homicide determined 28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	M 1 □Yes	2 🗆 No	28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	Hospital of hours a funeral Dely filled i		29a. Certifier (Check only (Ch	wledge, deat	h occurred at the time, vestigation, in my opinio	date and place, on, death occur	and due to the car red at the time, dat	use(s) and manner as te and place, and due	s stated. to the cause(s)
	Fo the vithin 2 Fo the I complet	Medical	one) and manner stated. 29b. Signature and title of certifier	\supset	29c. License nu			d. Date signed (Mont	h, Day, Year)
	->-0		1	_	D 00	61783		10/27	2011
	6		30. Name and ad ress of person who impleted cause of death (Item Chang Choi, Mb 100 Hospita	la) (Type,	d, Prince (Frederi	ck, ma	ryland 2	owns
į.	Sta Registr		31. Date filed (Month, Day, Year) 32. Day strar's Signal NOV 0 3 2011		arkel				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 **Physician** Year 10 28 Fredrick Wallace Tichnell 10:40 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Dennett Road Manor Nursing Home Garrett Oakland If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 05 28 1921 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1**X** M 2□ F Director 213-12-9328 90 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 XYes 2 No Garrett Mt. Lake Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 800 K Street 21550 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Meyes 2 No If Yes, Give 1943 Year or Dates: 1945 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1943 1 ☐Yes 2 ☐ No ğ Specify: 3 ☐ Widowed 4 ☐ Divorced White 1945 Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) clerk postal service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Tichnell Kathleen Junkins ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dawn Panther-daughter 109 Frazee Estate Drive, Oakland, MD 21550 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages Department of Important: If it any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cumberland Crematory 10/30/2011 Cumberland, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David A. Burdock Funeral Home PA 21 N 2nd St, Oakland, MD 21550 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between strick, or heart failure. List only one cause on each line Imm ciate Cause (Final disease or condition resulting in death) Onset and Death **Physician** aceiti myocardial hr /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-trar Physician/Medical CONUR 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 □ Yes 2 □ No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🗷 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral of the Hospital

P.O.

Registrar

Medical

a kaiser 31. Date (iled (Month, Day, Year) OCT 3 1 2011

29b. Signature and title of certifier

29a. Certifier

(Check only one)

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

oakland, MJ 21550

29d. Date signed (Month, Day, Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 14, 2017 Benjamin C. Turner 11:33 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Bowie Health Center Prince George's Bowie 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) PC. 14, 1954 **X** M 2 □ F Months Days Hours Min. Director 56 Pennsylvania 191-44-9313 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notifled at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No Bowie MD Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20721 U.S.A. 15105 Jennings Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married XX Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Black 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) State Department Computer Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H ပ Minnie Anderson Ben Turner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda B. Turner - Wife 15105 Jennings Lane, Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Resurrection 4 ☐ Donation 5 ☐ Other (Specify) 10-24-2011 Clinton, Maryland Cemeterv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 23 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hyart failure. Limit only one cause on each line.

Immediate Cause (Find disease or condition and the cause of the Approximate Interval Between Onset and Death Physician/ PCU Medical resulting in death) Examiner Sequentially list conditions, if any leading it immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 12 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident 2 🗌 No Investigation 1 Yes 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 GALCANT FOXLN State

Registrar

1920

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 📦 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 8:45 AM Uphold, Jr. Angelo October 2011 Theodore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Garrett Oakland 399 Hutton Road If Under 1 Year If Under 24 Hrs. . Social Security Number 8. Date of Birth g, Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Days 1 🂢 M 2 🗆 F Hours 1^{M2}/ Director 69 220-38-0288 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🂢 No Oakland MD Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21550 399 Hutton Road items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner n 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 X Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the M one. College (1-4 or 5+) 10 Logging Company Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Celo Guthrie Genevieve Uphold, Sr. Theodore Angelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 399 Hutton Road, Oakland, MD 21550 Mary E. Uphold/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bloom intory Rose eace) 10/25/2011 Friendsville, MD Cemetery 21. Strature Funeral Service Licenses 22. Name and Address of Facility Newman Funeral Homes P.A. Miller St., Grantsville, MD 21536 179 23a. Part 1. Enter the disease, or complications that the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Physician. disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): physician Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day 5 Other (specify) Pregnant at time of death sate has been signed by the a page 2 should be detached f g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by ancer 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performe After this certificate 1 Yes 2 No Yes 2 🗘 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

de

Daniel Α. Buckingham MD 31. Date filed (Month, Day, Year) OCT 2 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

255 North Fourth St., Oakland, Registrar's Signature

Nam

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3011

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October 15, 2011 Nancy Anne VenDouern 6:35 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Frederick 10123 Woodsboro Road Woodsboro Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2**X**X Days July 5. 1937 74 New Jersey Director 214-34-3198 Usual Residence of Decedent 10a. State 10b. County c. City, Town or Location
10123 Woodsboro Director 10d. Inside City Limits Maryland Frederick must be notified Woodsboro 1 Yes 2 No 10e. Street and Numbe 10g. Citizen of What Country? 10f. Zip Code **Completed by Funeral** 10123 Woodsboro Road 21798 ral", or items? Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black White etc 1 Never Married 2 Married 1 ☐ Yes 2XX No White 1 ☐ Yes 2 X No Specify: Specify 3X Widowed 4 ☐ Divorced Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur. other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Anna Elizabeth Mamber William Mathias Shipman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21798 Alan VenDouern - son 10123 Woodsboro Road, Woodsboro, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗌 Cremation 3 🗆 Removal from State 10-19-2011 Walkersville, Maryland 4 Donation 5 Other (Specify) Glade Cemetery Sign wre of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Hom e 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Interval Between Onset and Dem Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tes 2. No Other: 2 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Hame 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1. Natural (Month, Day, Year) injury work? 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

burial-transi attending physician for use as the buria requires that the death certificate be Box 68760 the P.0. signed by should be Division of Vital Records, neec this certificate has page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director, After completed filled in by the funeral

the Maryland

Page 1 and 2 should be filed within 72 hours after

Maryland 21215-0036

Baltimore,

28a-f

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23a

29a. Certifier (Check only one) 29b. Signature

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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29c. License number 29d. Date signed (Month, Day, Year)

City or Town, State)

who completed cause of death (Item 23a) Name and address of pers

2011

State Registrar

32 Registrar's Signature

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For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Gerardo Javier Valladares October 0808 Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 52 Forest Lane Ceci1 Chesapeake City Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1956 1 X M 2 □ F Days Hours Min March 26. Costa Rica 216-66-5022 55 Director Yrs. Usual Residence of Decedent 28a-f shov 10a State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Marvland Ceci1 Chesapeake City 10e. Street and Number 10g, Citizen of What Country? items 23a Funeral 52 Forest Lane 21915 United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 'natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 3altimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Costa Rican Specify: White Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiers Important: If item 27 is marked other than 'any injury or other traumatic event, the Menone. Elementary/Seconday (0-12) College (1-4 or 5+) Parks and Recreation Maintenance County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hugo Z. Valladares Grace Bermudez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolina M. Valladares/Sister 52 Forest Lane, Chesapeake City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 26 1 🐰 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Rose of Lima Cemetery Chesapeake City, MD 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals. P.A. 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Glioblastoma disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or at a consequence of, attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The I within 24 hours after death.
To the Funeral Director; After this certificate h performed? Yes 2 No 2 🗆 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 🕏 af certifier MD D0062190 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2533 AUGUSTINE HERMAN HWY, SVITE A, CHESAPEAKECITY, MOZI 915. SHAHNAWAZ KITAN 31. Date filed (Month, Đay, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 7/2009

Amended #8, nls, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10/18/11, per FD, State of Maryland / Department of Health and Mental Hygiene Allegany Co 35168 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donald Woodal Ray Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Western MD Regional Medical Center Cumberland Allegany 1938 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Country)
Pennsylvania Days Min. (Month, Day, Yea 03/30/19 1 🕅 M 2 🗆 F Hours Director 204-28-0811 Usual Residence of Decedent 28a-f show 10b. County ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director Allegany Cumberland 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10a, Citizen of What Country? Funeral 13206 Frantz Hollow Road, NE 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Bus Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ပ္ Viola Rohrabaugh Earl Truex Woodal Hazel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
13206 Frantz Hollow Road, NE, Cumberland, MD21502 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Audrey M. Woodal / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Cumberland Crematory 10/12/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Adams Family Funeral Home, Signature of Funeral Service Adensee 404 Decatur Street, Cumberland, MD Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disealle, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ACHTE MYOGMAIAL Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** EMPHYJEMA if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performe 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0034812 201 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Eugene P. Nallin, M.D., 909B Seton Drive, Cumberland, MD 32. Registrar's Signature State Darre Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Plea	ase Type or Pr State of M			ndelible In artment of			-		_	ole.	
		State Registrar 1. Decedent's Name	o /First Middle				tificate of				Reg. No	20		3516
Physicia Medio		Raymond	l Russ	ell Wilson						2. Date of De Month Octob		9 201 [°]	ear	3. Time of Death 6:10 A M
Examin		57 Cemet	ery Ro				4b. City, Town, o	burg	•		4c.	. County of Alleg	Death any	
Funeral Director		5. Social Security No. 218–50–0	599	6. Sex 1 X M 2 F	ge (In yrs. la 63	ast birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da OCt. 2	orth 0 194	48	9. Birthp Count Mary	place (State or Foreign tru) 1 and
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vith the Ma 23a or 28a st be notifi	Funeral Director	10e. Street and Num 19022	nber	al Pike	1		10f. Zip Code 215	32			-	tizen of Wh		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 Never Marri 3 Widowed		If Voc Civo		If	Vas Decedent of Information of Info	an, Mexican	, Puerto	ecify Yes or No- Rican, etc.)		14. Race -		an Indian, etc.
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nd 2 shoulk salth and N n 27 is ma er trauma		19a. Informant's Na Delores					g Address (Street tch Row,							Code)
Page 1 ar nent of He ant: If iter ury or oth		20a. Method of Disp 1 🛣 Burial 2 ↓ 4 🗌 Donation	Cremation	3 ☐ Removal from State		emetery, crem	sition (Name of natory or other pla 11 Cemet	ery 1		Date 1/2011	1	ton,		
permit. Departimort Import any inj		21. Signature of Fur	neral Service I	icensee Le Bor	l		. Name and Addre			oal Fun ternpor				21562
Physician/		shock, or hear Immediate Cause (F disease or condition	t failure. List o Final	complications that cause only one cause on each lin	e.		r the mode of dyin				rrest,			Approximate Interval Between Onset and Death
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	ll death 3 🗌	Ectopic pregnan Other (specify)	су			1	23d. Date o		ery Day Year
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he Hospit in 24 houn he Funera ipleted fille	Medical	(Check 2	Medical E	Physician: To the best of xaminer: On the basis of Nurse Practioner: To the	xamination	ı and/or investi	igation, in my opini	on, death oc	curred at	the time, date a	and place,	, and due to	the cau	se(s) and manner stated
Notth Con to		29b. Signature and t	ello of certifier	0 6/	rer	h	29c. Licens	e number	365	5		te signed (M		**
	2	30. Name and addre Dr. Robus	stiano	who completed cause of c J. Barrera,	leath (Item 200	23ay (Type, Pi Glenn	ST, Cumb	erlan	d, M					
Stat Registra	_	31. Date filed (Month	n, Day, Year)	011 32. Registr	ar's Signat	ure Land	w							
/H 17 Rev 7/20			, , ,	pentur	g.	1700								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For AMEND#16a, 23apart II State of Maryland / Department of Health and Mental Hygiene State Registrar AACO HEALTH DEPT. CMH 10/24/2011 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ 7:34 01 Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town 4c. County of Death Battimore Burnie Nashington 1 edices olen If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | A Month, 123 Year 1938 Social Security Number 7. Age (In yrs. last birthday. 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Pennsylvania 175-30-3306 Director 73 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 ☐ Yes 2 🖔 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7805 Bruton Dr. 21060 USA Apt D 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by "natural", or 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: **Black** 3 Divorced 4 Divorced Year or Dates Vietnam permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Dion 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Walter Reed Army Dignitary Elementary/Seconday (0-12) College (1-4 or 5+) 12th 2yrs Liaison for Foreign Dig Medical Center Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clyde White Nellie Mockabee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard J. White Jr(Son) Autumwood Prairieville, LA 70769 40143 S. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Maryland Veteran ! 10-21-11 Crownsville, Md. 4 Donation 5 Other (Specify) MMame are essent Sellit Sons Mortuary, 21. Signature of Funeral Service Licensee 1922 Forest Dr. Annapolis, Md. 21401 23a. Part 1. Enter the "sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ 1ear disease or condition Medical resulting in death) **Examiner** sion Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events ue to (or as a consequence of burial-trar Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 the for use as IF FEMALE 23b. Was decedent pregnant 23d Date of delivery in the past 12 months? Day 2 No 9 Unknown 9 Unknown þ Other significant conditions 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autops death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2**X**0 ပ္ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred I or Attending Patter death. (Month, Day, Year) Matural 5 Pending 24 hours after death. Funeral Director: Al 1 ☐ Yes 2 ☐ No Accident Investigation M Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and the and address of person who completed cause of death (Item 23a) (Type, Print) 0 105 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Vear Paul W. Weatherholtz October 0 Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Ellicott City Nursing & Rehab Ellicott City Howard 5. Social Security Number If Under 1 Year 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours West Virginia 10/18/1922 Director 234-26-9810 89 1 🔀 M 2 🗆 F show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 XNo Md. Howard Ellicott City ō 10e. Street and Numbe 10g. Citizen of What Country? must be Funeral 23a 4923 Harrogate Rd 21043 USA items Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ral", or iten Examiner r Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White "natural", 3 Widowed 4 □ Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Building Industry 10yrs Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert W. Weatherholtz Clara A. Fitzwater and lis m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Paula Gore/daughter 4923 Harrogate Rd. Ellicott City, Md. 21043 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o once. cemetery, crematory or other place) 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial 10/25/2011 Donation 5 Other (Specify) Elkridge,Md. 21. Si natu e of Funer I Servi y Licen ee 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 1000 4112 Old Columbia Pike Ellicott City,Md. 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ CARDIO RESPIRATORY Medical resulting in death) Examiner FIBRILLATION TRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): REIPIRATORY FAILURG CHRONIC burial-transi Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical HABEKLENTION certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death be detached 1 ☐ Yes 2 ☐ Unknown the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ▼ No 24a. Was an has performed? Yes 2 No 24 hours after death.

Funeral Director. After this certificate I letely filled in by the funeral director, pag Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2XX No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 Yes 2 No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of co 29d. Date signed (Month, Day, Year) 2 0062704 Name and address of person who c pleted cause of death (Item 23a) (Type, Print) 3290 N. R. Dge Rd

Registrar DHMH 17 Rev 06-2011

State

KARTIK

J.

MEISH

MD

gistrar's Signature

11-07821 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Rodney Dale Weicht State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 0909 hrs **Medical Examiner** October 18, 2011 Rodney Dale Weicht 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** oreign Mannyland Months Days Hours Director 49 Nov.29,1961 219-78-3563 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 YNo Md. Smithsburg Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, the Medical E-miner must be notified at once. Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 10837 White Hall Rd. U.S.A 21783 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 XMarried Yes White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: ፩ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Law Enforcement 12 Assistant Wardon 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joann Watkins Donald R. Weicht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10837 White Hall Rd. Smithsburg, Md. 21783 Linda J. Weicht (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) Oct. 26, 1 Burial 2 Cremation 3 Removal from State Smithsburg Crematory Smithsburg, Md. 2011 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 12525 Bradbury Ave. M01414 Davis Funeral Home Smithsburg, Md. 21783 Approximate Interval Between Onset and 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** failure. List only one cause on each line. /Medical Death a. Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last n and - transit cal AMENDED Icate has been signed by the attending physician page 2 should be detached for use as the burial -UNPENDED ician/Medi Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery 3 Ectopic pregnancy 1 Live birth Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Physi 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>a</u> 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed death? Yes 2 V No Yes 2 No After this certific funeral director, p 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 1 V Natural 1 Yes 2 No Pending 24 hours after death. To the Funeral Director: completely filled in by the Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the boot of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated S 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manger stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) October 19, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a)

QJ OCME

ORIGINAL

Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

DHMH 17 Rev 1/2001 OCMF 2006

State Registrar Mary G. Riggie MD.

31. Date filed (Month)

			Please Type or Print in Black			-	_	
			State of Maryland / De	epariment of he Certificate of De			0011	05170
			Registrar 1. Decedent's Name (First, Middle, Last)	bertimeate or be		Reg. Date of Death	No. Z	3. Time of Death
e	Physicia Medic	al	Glenn Ellsworth Warner Jr.		[0	ctober 2	27, 2011	8:44 A. ^M
1	Examin	er	4a. Facility Name (if not institution, give street and number) 1337 Weaverton Rd.	4b. City, Town, or Lo			4c. County of Death	
ă	Funeral Director		5. Social Security Number 6. Sex 7. Age (in yrs. last birthd) $219-60-4516$ 7. Age (in yrs. last birthd) $219-60-4516$	Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea an 31.10	9. Birth Cou. 054 May	place (State or Foreign htry) cvland
	d t	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town o	or Location				10d, Inside City Limits
	Marylan 18a-f sh Vified a	recto	,	ville				1 Yes 2 No
	vith the I 23a or 2 st be no	Funeral Director	10e. Street and Number 1337 Weaverton Rd.	10f. Zip Code	21758	10g.	Citizen of What Cou	ntry?
	r death v r items iner mu		Armed Forces?	13. Was Decedent of Hisp If Yes, specify Cuban,	panic Origin? (Specify Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Ameri Black, White,	
900	urs after tural", o al Exam	ted by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 Yes 2 No			Specify: Whi	te
215-	י 72 ho an "na l Medic a	Completed	(Specify only highest grade completed) (G	Decedent's Usual Occupation Give kind of work done dur fe. DO NOT use retired)	ion ring most of working	166	o. Kind of Business Ir	
212	l withir ygiene her tha t, the		12	Carpenter				ruction
land	l be filed fental Hy rked ott tic even	To Be	17. Father's Name (First, Middle, Last) Glenn E. Warner Sr.	1	18. Mother's Name <i>(Fii</i> Bett	rst, Middle, Maid y J. Smi	,	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 000	Mailing Address (Street and 2 Mid-Mt. La				
re,	1 and of Heal fitem ?		20a. Method of Disposition 20b. Place of D	Disposition (Name of crematory or other place)	Date	'	Location - City or T	
timo	it. Page rtment rtant: It njury or		4 Donation 5 Other (Specify)	t Valley Cem	2011	5	mithsburg	
Bal	permil Depar Impor any in		21. Signature of Funeral Service Licensee M01414	22. Name and Address J.L. Davis		1252 ome Smit	25 Bradbur Chsburg,Mc	y Ave. 1. 21783
	Physician/	,	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final					Approximate Interval Between Onset and Death
محديث	Medical Examiner	N (8)	disease or condition resulting in death) a. Due to (or as a consequence of):		mestre.	Car	amona	Tyters
L		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):					
	be executed ician and burial-transit	Examiner	Cause (Disease or linjury that initiated events cusulting in death) Last	:				
0	be ex	ल्ल	L _{d.}					
876	ificate ng phy as the	Med	IF FEMALE:					
. Box 6876	To the Hospital or Attending Physician: The law requires that the death certificate by within 24 hours after death. Of the Funeral infector Adth. Completed filled in by the funeral director, page 2 should be detached for use as the b	Physician/Medic	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)			23d. Date of deli Month	very Day Year
, P.O	requires that the der been signed by the s should be detached	<u>중</u>	Part II. Other significant conditions contributing to death but not resulting in t	the underlying cause giver	n in Part I.		co use contribute to	the cause of death?
ords	requir been s should	letec	100			24a. Was an	24b. Were aut	opsy findings available
Reco	rsician: The law r s certificate has b lirector, page 2 s	Completed				autopsy performed 1 Yes 2	? death?	ompletion of cause of
ta	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:	26. Plac	e of Death (Check onl	y one)		
Ž	Physic this cral dir	. To	1	patient 3 L DOA	4 ☐ Nursing Home	5 Residence		<u>5y)</u>
o uo	eth. r: After re fune	icate	1 ☑ Natural 5 ☐ Pending (Month, Ďay, Year) inju 2 ☐ AccidentInvestigation	ury work?	es 2 🗆 No	Describe flow ii	ijury occurred	
Division of Vital Records, P.O.	al or Attending Phys s after death. I Director: After this d in by the funeral di	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	ı, street, factory, office	28f.	Location (Street City or Town, St	t and Number or Run ate)	al Route Number,
_	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, decorate (Check only one) 3 Certifying Nurse Practioner: To the best of my knowledge.	investigation, in my opinion,	death occurred at the	time, date and pl	ace, and due to the c	ause(s) and manner stated.
	To t with To tll	_	29b. Signature and title of certifier	29c. License n	number 7 7	29d.	Date signed (Month,	Day, Year)
	V		30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	Neday.). Cin	anus D	الما
	Stat		31. Date filed (Month, Day, Year) 32. Jegistrar's Signatur	Part de		1 (1	10.1
DHN	Registra MH 17 Rev 7/20		NOV 0 3 2011 Sour B.	y are		1 109	NC form	21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10-15-2011 Howard R. Yeatman, Jr. 2:40 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 1609 Hudson Road Cambridge Dorchester Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) England 1 💢 M 2 🗆 F Months Days Hours Min (Month, Day, Year) **Director** 218-40-7366 66 Usual Residence of Decedent Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland at Director r 28a-f sh notified a 1 ☐ Yes 2 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a on traumatic event, the Medical Examiner must be i Funeral 1609 Hudson Road 21613 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor US Postal Service Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy, Important: If item 27 is marked oth any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Howard R. Yeatman, Sr. Phyllis Colborne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda J. Yeatman (wife) 1609 Hudson Road Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Spring Hill Cem. 10-19-2011 Easton, MD 22. Name and Address of Facility
Fellows, Helfenbein & Newnam Funeral Home, P.A.
200 S. Harrison St Easton MD 21601 r f Service Lice 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-trans Due to (or as a consequence of) signed by the attending physician and be detached for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 💢 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has performed? 2 🗌 No 1 T Yes Yes 2 No 25. Was case referred to medical l e 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{R}\) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 No ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After Natural 5 \square Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

24 hours after death Funeral Director: within 2

> STVA State

Registrar DHMH 17 Rev 7/2009

only one) 29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

18 2011

509

MD Registrar's Signature

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

idlewild

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Koffi Mawuko Afantolou October 26, 2011 8:34 a.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1814 Metzerott Rd. #12 Hyattsville Prince George's Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year | If Under 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, Year) Months Days **Director** 212-71-7241 1 🖾 M 2 🗆 F 50 Yrs. Aug. 11, 1961 Togo Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location at 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified. MD Prince Georges Hyattsville 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1814 Metzerott Rd. #12 20783 Togo within 72 hours after death 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: **Black** Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Meat Cutter Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Kossi Afantolou Afiwa Apaloo permit. Page 1 and 2 shoul
Department of Health and I Important: If item 27 is m any injury or other traums once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yawa Agbodoza (wife) 1814 Metzerott Rd. #12 Hyattsville, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Gate of Heaven Cem. 11/03/2011 Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Rapp Funeral & Cremation Service MO153 933 Gist Ave. Silver Spring, Maryland 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ACUTE RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** METASTATIC CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence on CARDIAC ARRHYTHMIA burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical ANEMIA Box 68760 use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPONATREMIA 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed?

Yes XX No. **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2X No Hospital: Other: 2 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) completely filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending P 24 hours after death. Funeral Director; After the Certificate: 28c. Injury at 28d. Describe how injury occurred After 1XXNatural injury 5 Pending work? 1 ☐ Yes 2 ☐ No М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 To the I within 2 To the I only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) November 3, 2011 D52855 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7207 Hanover Pkwy. "B", Greenbelt, MD Chandrasekhar Korapati M.D., 31. Date filed (Month; Day, Year) 32. Pagatrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Degedent's Name (First, Middle, Last) 2 Date of Death 58A M **Physician** 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 SF 89 Yrs 220-05-1714 PĔŇŇSYLVANIA 3-14-1922 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show must be notified at N/A HIGHLANDTOWN 1X Yes 2 □ No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 400 KANE STREET 21224 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. the Medical Examiner 2 should be filed within 72 hours after a and Mental Hygiene. Is marked other than "natural", or ite 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Xio Specify: þ Specify: WHITE 3 X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) SOCIAL SECURITY FILING 11 Department of Health and Mental Important: If item 27 is any injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic event, Be PASOUALE STABILE ELIZABETH GIANELLI ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JUDITH STURGILL/DAUGHTER 1603 SUMMIT AVENUE ROSEDALE, MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State OAKLAWN CEMETERY 11-7-2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 pproximate nterval Between laset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) aav< **Physician** wou aron /Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ue to (or as a consequence of) CumoNi Attending Physician: The law requires that the death certificate be executed the burial-trai resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown P.O. ρλ been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 🗌 No 3 🔲 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has performed. 1 ☐ Yes 2 ☐ No 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Inpatient Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Tes 2 ER/Outpatient 3 DOA ၉ After this 27. Manner of Leath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: io the Hospital or Atten.

- 24 hours after death.

- al Director: Af 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES-000 NOVEMBER 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DANIEL A. KIM, MD 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

NOV 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Amore 7. Age (In yrs. last birthday) 82 vre If Under 24 Hrs. 8. Date of Birth Sex 9. Birthplace (State or Foreign **Funeral** 071-20-3039 Months Days Min Country) 1 🔀 M 2 🗆 F **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County Howard 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Columbia 1 Yes X No 10f. Zip Code 21046 10e. Street and Number 10g. Citizen of What Country? ō and Mental Hygiene. is marked other than "natural", or items 23a or aumatic event, the Medical Examiner must be Setting Sun Way 7437 Funeral USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 🗶 No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: White 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) HVAC Executive Be 17. Father's Name (First, Middle, Last) Alexander 18. Mother's Name (First, Middle, Maiden Sumame) Addy ည Della Marone ^{19a.} Informant's Name/Relationship (*Type, Print*) Ann Bernard Addy/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7437 Setting Sun Way, Columbia, MD 21046 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Durial 2 X Cremation 3 Removal from State cemetery, crematory or other place)
Chesapeake Crematory Beltsville, MD 11/3/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Addre Funeral Service Licensee Doropa Marshall ryfand Cremation Services Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a con quence of): **Examiner** Sequentially list conditions, Examiner Due to (Chas a consequence of): If any, leading to immediat cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and for use as the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) signed by the ard d be detached for q Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? Yes 2 No After this certificate has completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 Accident 2 🗌 No 24 hours after death. Funeral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 32. Registras Signa

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street and number) Examiner BALTO. more If Under 1 Year Months Days If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours Months 21220 9012 MARYland Director Usuel Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Marylend Hygiene. 10c. City, Town or Location 10b. County permit. Peges 1 end 2 should be filed within 72 hours after death with the Maryler Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 12 Yes 2 □ No BALTIMORE, MARYLAND BALTO. MD. Funeral Director 10g. Citizen of What Country? 10e Street and Number 4517 6040 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Ney 2 □ No If Yes, Give Year or Dates: 11 Marital Stetus 1 Never Married 2☐ Married 1 ☐ Yes 2 No Specify Specify: BLACK Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0,12) College (1-4or 5+) INDUSTRIAL ANITOR UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNKNOW 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 201 BALTIMORE BALTO. MD. 21202 SOCIAL E. WORKER ARTIK SHAW 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition CROWNS VILE, MD. 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9 ROWNSVILLE UETERAN 21. Signature of Euneral Service Licensee 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. SKARDA FYNERAL HUME, 1829 HUDSONST. BALTA, MD. Physician Immediate Cause (Final disease or condition resulting in death) demente /Medical Examines Completed by Physician/Medical Examiner tor: After this cartificate hes been signed by the ettending physicien end the funerel director, pege 2 should be detached for use es the burial-trensit The lew requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): resulting in death) Lest 23b. Did tobacco usa contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yas 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy after death.

Director: After this certificate hes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√ No 2 ER/Outpatient 3 DOA edicai Certification: To 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30 Name and address of person who completed cause of death (Item 23e) (Type, Print)

State Registrar 32. Registrer's

BURRIS, ANDREW DAVID

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man of the second	Funeral		VA MARYLAN 5. Social Security Number	D HEAL	THEARE S	YSTEN je (In yrs. la:		PERRY If Under 1 Year	_	DINT der 24 Hrs.	8_Date of Bir		LECI!	irthplace (State	or Foreian
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0036	urs afte tural", al Exan	ted b	3 Widowed 4 D	ivorced	1 ▲ Yes 2 ☐ If Yes, Give Year or Dates.	1974-	-75	1 ☐ Yes 2 🕱 N	o Spec	cify:			Specify: Wh	ite	
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Baltimore, Maryland 21215-0036	le 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Re Shelly Bu					ng Address (Stree							
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. B 0)	ne death the attuched for	Physician/Medical	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5?	4 Pregnant a			Other (specify)					Month	Day	Year
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, Hidre this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by	Part II. Other significant of	conditions co	ntributing to death b	out not resu	Ilting in the u	ınderlying cause ç	jiven in Pa	art I.			use contribute	_	
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Vita	hysicia nis certi I directe	To Be	examiner? 1 Yes 2 No	-	lospital:	ent 2 🗆 E	ER/Outpatier		her	Death (Check Nursing Hor		dence	6 ☐ Other (Spe	ecify)	
n of	iding Pl th After th			Pending	28a. Date of inju (Month, Day		28b. Time of injury	wo			28d. Describe	how inju	ry occurred		
visio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Certificate;		Investigation Could not be determined	28e. Place of Injubuilding, etc		ne, farm, str	eet, factory, office			28f. Location (City or To		nd Number or R	ural Route Nui	mber,
۵	spital c		29a. Certifier 1 X Ce	rtifying Physi	cian: To the best of	my knowle	edge, death	occured at the tim	e, date a	nd place, and	d due to the ca	ause(s) a	nd manner as s	tated.	
	the Ho	Medical	only one) 3 \square Ce	rtifying Nurse	er: On the basis of e Practioner: To the			leath occurred at t	he time, d	date and place		ne cause	s) and manner a	s stated.	manner stated.
	No Noit		29b. Signature and title of	certifier	as A	Bu	arelo	29c. Licen	280				ate signed (Mon		110
	2		30. Name and address of p	person who co	impleted cause of d	leath (Item :	23a) (Type, F	Print\		-					
	Stat	e_	Thomas 31. Date filed (Month, Day,	Year)	32. Registra	ar's Signatu	VA M	bnalys	Hea	JHHC	Are Sys	*M	tery to	oint, M	·D
	Registra		NOV 0 4 201	1 Den	we B.	par	Ked								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day 8:55PM Physician/ Bartow)a calyn october 76 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Howard Columbia 5802 Wyndham Circle, #104 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Social Security Number **Funeral** Director 113-42-8652 1 □ M 2 🛛 F Yrs 03/03/1957 New Jersey Usual Residence of Deced 54 ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2 No Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 21044 5802 Wyndham Circle, items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 X Married by 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify. permit. Page 1 and 2 should be filed within 72 hours a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic event, the Medical Expone. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Education Professor 5+ Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ၉ Dorcas Marilyn Howard Bartow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5802 Wyndham Circle, #104, Columbia, MD 21044 <u>Pam Demartino / Spouse</u> 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 🕅 Donation 5 ☐ Other (Specify) 11/02/2011 Hanover, Maryland Anatany Gifts Registry Anatomy Gifts Registry Signature of Funeral Service 22. Name and Address of Facility 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Peritonea Physician/ (ancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate sician and burial-transit The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the a g Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an autopsy certificate has performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director. After this completely filled in by the funeral of 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manger of Death 28c. Injury at Certificate: injury To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No Investigation ☐ Accident☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nA/CajapahleM.D DO057465 10/3//11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 2835 Smith AV 5 703 N.S. Kninpakse, M.D 31. Date filed (Month, Day, Year) 32: Registrar's Signature State NOV 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death Physician/ 2011 November Debra Jean Bare Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Harford 2001 East Wheel Road Air 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** or. 13 1 □ M 2 🔀 F Months Days Hours ^{Year} 19<u>57</u> Maryland 54 Apr. **Director** 215-74-0635 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ** Once. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🛂No Maryland | Harford Bel Air 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 2001 East Wheel Road 21015 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Shoe Manufacturer Factory Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Thelma Jean McMillan Ules Barnie Bare 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ricky J. Bare / Brother 24 Meadow Drive, Northeast, Maryland 21901 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-7-2011 Colora, Maryland New Bridge Cemetery 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Metastatic Plu ician disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Brother S 2 1 No 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Residence 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 2 \square No Investigation 2 Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my oplinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. Hovember Third 2011

Registrar

State

31. Date filed (Month, Day, Year)

er Chesaveake Drive # 409

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo Min(M.D.) 510 Upper Chusay

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month NOVEMBER Physician/ 0035 SELMA 201 01 Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE SECOURS 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth . Social Security Number **Funeral** 6-4964 1 M 2 Months Davs Hours Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10b. County traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2 No Baltimore MD 10g. Citizen of What Country? ö 10e. Street and Number 10f. Zip Code 23a Funeral Bloom or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 2 No Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced "natural", Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked any injury or cat-Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname) ည Gamhle Ellinaton Maymond 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship , ype, Print) B100m 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) arrison 21. Signatur of Funeral Service Licensee Approximate Interval Between Onset and Death Physicians PNEUMONIA Medical resulting in death) Due to (or as a consequence of): **Examiner** PULMONARY DISEASE CHRONIC OBSTRUCTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 Fetal death in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Hospital or Attending Physician: The law requires MELLITUS DIABETES To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? 2 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide work?
1 Yes 2 No 5 Pending 24 hours after death. Funeral Director: A Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D30272 NOVEMBER 01 2011 ne mella 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAXYLAND 21223 BALTIMORE MILLER HOSPITAL BON SECOURS

Registrar

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND ITEM#5perFH, G921, 11/9, Z011, WS
State of Maryland / Department of Health and Mental Hygiene For State Reg. No. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Karen NOV 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hedical Baltimore Of Mayland If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Hours Min Director 1 M 2 F 5-6-1957 MARYLAND 54 Usual Residence of Dec 28a-f show 10a. State 10d. Inside City Limits with the Maryland at 10c. City, Town or Location Director MD BALTIMORE ROSEDALE notified 1 Yes 2 XNo Ь 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be 1414 PEPER AVENUE 23a Funeral 21237 U.S.A. items filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Medical Examiner Armed Forces? Black, White, etc. o. 1X Never Married 2 ☐ Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: "natural" WHITE Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the MANAGER BOWLING ALLEY Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Himportant: If item 27 is many injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DONAL LEVI BRISON NANCY LEE THOMAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MARK BROCKELL/FIANCE 1414 PEPER AVENUE ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State METRO CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 11 - 3 - 11CATONSVILLE, 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME Signature of Funeral Service License 21237 1211 CHESACO AVE ROSEDALE, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph. i. ian. bacterial 500515-Saona disease or condition Medical resulting in death) Due to r as a consequence of **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence on the burial-transi Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the at Id be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 Yes 2 No ပ္ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 3 [only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 2011 740597038 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. Grene St. Baltimore, MD 21201 au /athcome 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

14

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 35184 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER ano 48 PM Medical la. Facility Name (if not institution give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death rear olumbi towa Social Security Number 9. Birthplace (State or Foreign If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth **Funeral** Country) 1 3M 2 5 Min. brea Director Usual Residence of Decede permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Funeral Director 1 Yes 2 □ No imbia toward 01 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8825 2104 as 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Syrname, မ ama tae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 01 Way 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) ueadow ridge 21. Signature of Funeral Service Licer Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. astatic Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that better and the cause of the cause Due to (or as a consequence of): Physician/Medical Exam • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the buria P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 2 No 3 Probably 4 Unknown 1 Yes plnous 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 After this certificate has funeral director, page 2: Division of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred Natural injury 5 Pending 2 No Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifier D54413 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North DR. 5.140

DHMH 17 Rev 7/2009

State Registrar

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end #5 Per FH G922 12/LS/Polities of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician tober 2011 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner altomore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 250 – 39 – 69 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours -698 1 □ M 2 □ March 28 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other thaumatic event, Ira Medical Examiner must be neatlined at ury or other thaumatic event, Ira Medical Examiner must be neatlined at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Des 2 No Directo Homoro 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21211 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 ₩ If Yes, Give Year or Dates: 2 No 1 ☐ Ngver Married 2 ☐ Married Baltimore, Maryland 21215-0036 2 No Blac. 1 □ Yes δ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) se Kee 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) salti more ucia imes 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any Injury or o once, 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State altimore 22. Name and Address of Facility Funeral Service L 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician sonra disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed the burial-trai Due to (or as a consequence of): Box 68760. physician Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. s been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 🗌 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe To the Hospital or Attending Physician; The 2 No 2 1 ☐ Yes Division of Vital After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending within 24 hours after death. **To the Funeral Director**: A completely filled in by the ft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 28/11 D712 30. Name and address of person who completed dause of death (Item 23a) (Type, Print) UZO NN EGBU, MD \$35 Sm 174 AVE #203 BALTIMORE, MD 31. Date filed (Month, Day, Year) NOV 0 4 2011 State Registrar

DHMH 17 Rev 1/2001

35186

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death RIDGEFORD Physician/ PPOS 0454A Medical Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** OSPITAL NA If Under 1 Year If Under 24 Hrs. Marry and or Foreign 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Day, Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 Yes 2 No Honore 10e. Street and Number 10g, Citizen of What Country? Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retined) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 000 Be 17. Father's Name (First, Middle, Last) 18. Name is Name first Middle Maide permit. Page 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evides. ပ James Banbien 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) towell 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Ph_sician/ disease or condition resulting in death) Medical Examiner vere Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 1 Yes 2 1 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 No မ 1 🛄 Yes 1 🗹 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: the Hospital or Attending Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 eand address (Person who completed cause of death (Item 23a) (Type, Print) BACTIMORE, MD JOSEPH 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William J. Brooks 0831 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. AGNES us BALTIMORE HOSPITAL 5. Social Security Number **Funeral** . Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 🖟 M 2 🗆 F Months Days Hours Min. (Month th, Day, Year) Apr 15, 1931 219.28.2609 Director 80 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Howard Ellicott Clty 1 🗌 Yes 2 📮 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5201 Kerger Road 21043 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 A Married Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify: "natural" Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Civil Engineer **Baltimore City** 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F William E. Brooks Lilly Moerkin permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris L. Brooks Spouse 5201 Kerger Road Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State **Crest Lawn Memorial Gardens** Nov 03, 2011 Marriottsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 21. Sonature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph sician/ Aurtiz disease or condition resulting in death) Critizal months Medical Due to (or as a consequence of) **Examiner** Cardingeric Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami Hospital or Attending Physician: The law requires that the death certificate be executed Fibrillation Atrial burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician ause as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Pregnant at time of death signed by the aid be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performe 1 Yes 2 No Yes 2 A 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 W No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) the funeral Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) injury after death. Accident 1 Yes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a, Certifie 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

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State

Registrar

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CATON

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KALEEL

MOHAMMED

NOV 0 4 2011

31. Date filed (Month, Day, Year)

P 26431

BALTIMORE

Amend 25, per me, g922 12-2-11 sm Please Type or Print in Black Indelible Ind. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month TACKLYN BORTHWICK 9:05 OCTOBER Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Columbia 5400 Vantage Point Rd. Apt. 909 Howard 1932 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1932 (Month, Day, Year) Apr 11, 4934 **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 F Days Hours Min. Country) 394-26-2008 80 WI **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Howard Columbia 1 🗆 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 5400 Vantage Point Rd. Apt. 909 U.S.A. 21044 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian the Medical Examiner Black, White, etc. ö ģ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No White "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 7: Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker **Own Home** or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas F. Lekvin **Eleanor Carey** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau once. Robert Paul Borthwick Son 14221 Day Farm Rd. Glenelg, MD 21737 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 1 Burial 2 Cremation 3 Removal from State 4 Penation 5 Other (Specify) cemetery, crematory or other place **Forest Hill Cemetery** Nov 05, 2011 Eau Claire, WI Funeral Service Lice 21. Signatur 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 temballe, 1400533 t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Cerebral Bleed Immediate Cause (Final Seconds ath Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER signed by the attending physician and dbe detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death g Unknown Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, should t 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed death? this certificate 1 Yes 2 No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 1 🗌 Yes 2 No within 24 hours after death To the Funeral Director: / completed filled in by the f Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖂 To the only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie m) hun 31 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (olembia 92115 (eden lary

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 4 2011

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JACKLYN

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ $20\overset{\text{Ye}}{1}$ James Rolland Condee Nov. 1:45 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sanctuary at Holy Cross Burtonsville Montgomery 8. Date of Birth (Month, Day, Yea Jan. 11, If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days V<u>irginia</u> 1 🙀 M 2 🗆 F 1923 Director Yrs Jan. 228-14-7757 88 Usual Residence of Decedent 28a-f show 10d. Inside City Limits must be notified at 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 🔀 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 14035 Castle Blvd. #302 20904 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or iter ledical Examiner r 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Yes 2 No If Yes, Give Black, White, etc. δ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify; Completed 3 Widowed 4 Divorced White Year or Dates. W.W. II event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Federal Government Elementary/Seconday (0-12) College (1-4 or 5+) 12 White House Maintenace_Person Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental I မ (Ukn) (Ukn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health 14035 Castle Blvd. #203, Silver Spring, MD Cecilia D. Condee / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory : 11/04/2011 Beltsville, MD Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a, Part 1. Enter the disease, or com the trans that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Znd disease or condition Medical resulting in death) Due to (Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury Exam use as the bunal-transit that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b, Were autopsy findings available 24a. Was an has prior to completion of cause of death? performed? 1 Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at ie Hospital or Attending Pl n 24 hours after death. ie Funeral Director, After t Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending 1 Yes 2 Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

To the within 2

State Registrar only one)

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

NOV 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9801

29c. License number

D0054566

Georgia Arnu # 117, Silvespring mn 2 000

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Chappell Month Ines 11:45A M November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Season's Hospice Randallstown Baltimore 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Hours Country) 217-20-1803 Director 1 🗆 M 2 💢 🖹 86 02 08 25 MD Usual Residence of Decedent show at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director event, the Medical Examiner must be notified MD 28a-f NA Baltimore 1 X Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? Funeral 1 and 2 should be filed within 72 hours after death with rif Health and Mental Hygiene.
item 27 is marked other than "natural". or items 29a 4908 Poe Ave 21215 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Force Black White etc 0 Completed by 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes Give Specify:Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry Il Hygiene. life. DO NOT use retired) 12th grade College (1-4 or 5+) Manicurist Barber Shops Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George Chappell Ida Mae Bell other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mederith Chappell Sr-Nephew 4908 Poe Ave, Baltimore, Md 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 Department of I Important: If it any injury or of once. Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Druid Ridge 11/8/2011 Pikesville. Md 22. Name and Address of Facility ARCH F/H West 4300 Wabash Ave, Baltimore, Md 21215 f Funeral Service Licensee 21. Sign 23a. Part . Enter the disease, or complications that caused shoot, or heart failure. List only one cause on each line. Interval Between Onset and Death Atheroscienti audiovascular Distust Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Dive to for as a ponsequency of To the Hospital or Attending Physician: The law requires that the de. th certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the "ttending physician and completely filled in by the funeral director, page 2 should be detached for use, as the burial-fransis that initiated events Due to (or as a consequence of): resulting in death) Last tending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month Pregnant at time of death Day 1 Yes 2 L 9 Unknown 9 | Linknown Division of Vital Records, P.O. signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🖪 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other Specify Ent Nospice 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending М 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Ms Ry wpolum M.D 00057465 11/3/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore MD ZIZOG N S Rajapaksem. O 203 2835 Smin N 31. Date filed (Month, Day, Year) State NOV 0 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Lena Belle Caron November 10:50 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Victorian Estates Assisted Living Bel Air Harford 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day Year)
June 15, 1929 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Virginia 1 🗆 M 2 🖾 F Days Hours Director 223-32-0223 Yrs 82 Usual Residence of Decedent 28a-f shov 10b. County the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 ¥ Yes 2 □ No Maryland Harford Bel Air 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a by Funeral 623 Dorsey Road 21014 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Black, White, etc. "natural", or Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Horticultural Elementary/Seconday (0-12) College (1-4 or 5+) **Estate** Director Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Mental Important: If item 27 is markany injury or other? and Mental Bernard Otto Belton Elizabeth (nmn) Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roger G. Caron / Husband 623 Dorsey Rd., Bel Air, MD 21014 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp. ! 11-4-11 Towson, Maryland McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ LESPINATON4 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner , mores AMYSTRUPHIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) CHRONIC OBSTRUCTURE the attending physician and hed for use as the burial-tran resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No Yes g Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ٥ 174 DENTENSION 2 🚧 o 3 🗌 Probably 4 🗌 Unknown 1 🗌 Yes Completed CANDID JASCULM DIDENSY 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? MIEMOSCEERONC has autopsy performe this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certified 25. Was case referred to medical completed filled in by the funeral director, To Be 26. Place of Death (Check only one) examiner? ASSISTE 2 🗷 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec J. NG Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the less of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D0028812 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Vincent A. Dipietro

32. Registrar's Signature

7801 York Road, Suite 102, Towson, MD 21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 11 Physician/ O1 2011 Crawford Catherine 7:00a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1020 East 33rd Street Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. (Month, Day, Year) 1 - M 2 F Director Yrs 219-18-0461 88 12 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a, State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 X Yes 2 No NA Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral 1020 East 33rd Street 21218 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 . 2 🔀 No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2X No Specify. X☐ Widowed 4 ☐ Divorced Completed Year or Dates. 27 is marked other than "natur traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
Baltimore City 15 Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bth grade Janitor na Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tom Hunt Lula Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Barbara Aulu-Daughter 4044 Forest Island Dr, Orlando, FL 32826 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1:
Department of I
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 11/12/2011 Woodlawn, Md 21. Signature of Funeral Service Licensed 22. Name and Address of Facility March F/H West 4300 Wabash Ave, Baltimore, Md mom 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alzhemer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed burial-transi and Due to (or as a consequence of) physician Physician/Medical for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral C Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Sertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 125808 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. Charles St *4105 TOWSON, MD 21204 ewis 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Michael John Cari		i, Jr S I-For State Registrar	tate of Maryla		epartme C <i>ertifica</i>			d Ment	al Hyg		eg. No.	20	1 1	3519
Physiciar Medical Examin	1/	1. Decedent's Name (First, Midd Michael John		. Jr	*-	,				Date of Dea Month October 1	ith Day	Year 1		ime of Death
		4a. Facility Name (if not institution 1627 Eastern Avenue	on, give street and nur			41	. City, Town, or Baltimore	Location of				County of I	Death	
Funeral Director		5. Social Security Number 212-36-4838	6. Sex	7. Age (In)	yrs. last birth	day) Yrs.	If Under 1 Yea Months Day		Min.	3. Date of Bir	`]F	9. Birthplac oreign Country	•
	II DIRector	Usual Residence of Decedent 10a. State MD 10e. Street and Number 1627 Easter 11. Marital Status 1 Never Married 2 M	12. Was Dece arried Armed Fo	Apt.	405	nore	City 10f. Zip Code 21231 Decedent of His			fy Yes or No	USA		1 [Country?	Yes 2 No
2 hours after "natural",	Completed by Fu		orced If Yes, Give Year or Dates:	e complete	r 55	ecedent's uring mos	Ves 2 No Usual Occupat the of working life	ion (Give ki DO NOT u			16b. Ki	Specify: Wind of Busin		
1215- I be filed ental Hyg rrked off	o De	17. Father's Name (First, Middle, Michael John 19a Informant's Name/Relations Kimberly Car	Carrick hip (Type, Print)		19b.		Address (Stree	Elea	anor per or Rura		SE H	arri y or Town,	State, Zip (
Baltimore, MD 2. permit. Pages 1 and 2 should Department of Health and Mc Important: If item 27 is ms injury or other traumatic		Kimberly Car 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Sp 21. Sign of Funeral Service	n 3 Removal fro pecify:			ry or othe .ew (on (Name of cer r place) Crematome and Address	ory 1	10-2	0-201	1 Ba	ltim	ore,	
Physician Medical examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, ff any, leading to immediate	on each line.	Cirr consequen	chosis	PA enter the	2134 mode of dying,	Will such as car	LOW :	<u>Sprin</u>	ig R	oad.	212 Ap	22 proximate Interval etween Onset and Death
box 68760, the death certificate be executed by the attending physician and ched for use as the burial - transit	iedicai	cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last X UNPENDED FFEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unkerted	23c. If yes, of	3a,27 utcome of p	7, per pregnancy	Feta	921 11-6 death 3 [S m pregnancy			Date of de	livery Day	Year
(ecords, P.O. Barthe de law requires that the de are has been signed by the age 2 should be detached formulated by Physics	5	Part II. Other significant conditi			not resulting	in the und	derlying cause g	iven in Part	i I.		an 2	No 3	Probably e autopsy	ause of death? 4 Unknown findings available etion of cause of
Division of Vital Records, tal or Attending Physician: The law require and or Attending Physician: The law require and alter dear. After this certificate has been sited in by the funeral director, page 2 should the artification: To Re Commission.		25. Was case referred to medical examiner? 1 Yes 2 No 17. Manner of Death	Hospital: 1 In In 28a. Date o	patient 2 f Injury Day,Year)		patient :	DOA DOA 28c. Injur	of Death (COther	Nursing H		2 No	ce 6 🗸 (Yes	2 No
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Pureral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bunificial Certification: To Be Compulated by Physicial Medical) <u> </u>	2 Accident Invest 3 Suicide 6 Could deter 9a Certifier Check only 1 Certifying Pt	28e. Place (Specify) sysician: To the best miner: On the basis of	of my knov	wledge, deat	occurre	factory, office b	te and place	e, and due	or Town, S	tate) e(s) and	manner as	stated	oute Number, City
To T		9b. Signature and title of certifie	7 M. 2	of death (*		29c, License O.C.M	И.Е.		D 01055		ate signed ber 15, 2		ay, Year)

Registrar

31. Date filed (*Month, Day*, Year) NOV 0 4 2011

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Physician/ 19:54 M MERISA GARCIA CONTRERAS OCTOBER 2011 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY SHADY ROCKVILLE ADVENTIST GROVE HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth Age (In vrs. last birthday) **Funeral** Min Country)
MARYLAND 1 - M 2 X F Director infant Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Gaithersburg Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20877 18029 Fence Post Court 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 XMarried 1 Yes : 1 X Yes 2 ☐ No Specify: hispanic mexican Specify: 3 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant infant infant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Katy Contreras Jhonys Guzma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 850 Medical Center Drive Rockville, MD 20850 Shady Grove Adventist Hospital 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🛛 Other (Specify) in state Funeral Service icensee RODAL S Wa ²State^{ad} Addat & My Board 655 W. Baltimore Street rector 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ EXTLEME PREMATURIT disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [출 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown cate has been signated based to Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗌 No certificate 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 1 🗌 Yes 2 1 No Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D 29a. Certifier Effectifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certify 30. Name and address deperson who completed cause of death (Item 23a) (Type, Print) 9901 MEDICAL CENTER DRIVE ROCKVILLE BURTON MP MARYLAND

Registrar

31. Date filed (Month, Day, Year)

NOV

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep	artment of Health and N	Mental Hygien	е
				rtificate of Death	Reg. N	·2011 35196
н	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death Month Date	3. Time of Death
,com.	Medic		LEUNG TUAN CHIU		10-26-20	
	Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death rince George's
390000	Funeral		Larkin Chase Nursing & Rehab 5. Social Security Number 6. Sex 7. Age (in yrs. last birthday)	Bowie If Under 1 Year If Under 24 Hrs.	8. Date of Birth	C. Birtheless (State or Femige
	Director		579-76-8987 ¹ M ² □ F 75 Yrs.	Months Days Hours Min.	1 2 nonth, 2 ay, Year)	35 Country China
	d ow		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Letter to the county			10d. Inside City Limits
	ırylanı 1-f sh 1ed a	Director				1 X Yes 2 □ No
	or 28a	Pie	MD Prince George's Upper M	ariboro 10f. Zip Code	10a. C	Sitizen of What Country?
	with ti	eral	9507 Tiberlas Drive	20772		SA .
	tems remi	Funeral	11 Marital Status 12 Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
36	ifter d ", or i amin	þ	1 Never Married 2 X Married 1 Tyes 2 TNo	1 ☐ Yes 2 🙀 No Specify:	riidari, etc.)	Black, White, etc. Specify: Asian
Ö	ours a	Completed	Year or Dates.	dent's Usual Occupation	140	Holdii
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212	within giene er tha , the l		Elementary/Seconday (0-12) College (1-4 or 5+) COO	k	Pr	ivate Industry
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	2		(Unav.)		(Unav.)
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altir	mit. Partme			2. Name and Address of Facility	70 2014 5	20746
ñ	permi Depar Impo any ir		Dousha h. Reid MO 1616 C	edar Hill FH,41	11 PA Av	e.,Suitland, MD
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
april -	Physician/		Immediate Cause (Final disease or condition Bone Marrow Fa	ilure		Onset and Death
	Medical Examiner		resulting in death) Due to (or as a consequence of):			
		er	Sequentially list conditions, if any, leading to immediate Myelofibrosis Due to (or as a consequence of):			
(2)	ted I Insit	Examine	cause. Enter Underlying Cause (Disease or iinjury			
	execu an and ial-tra	EX	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
00	icate be executed physician and is the burial-transit	dical	d			
387	rtifica ling ph e as tl	Physician/Me	IF FEMALE:		Т	
Box 687	ath ce attend for us	ian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ĕ.	the a	ysid	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown			
P.0	that the red by detail	by Pł	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
JS,	uires in sign	ed b	Anemia, severe		1 🗆 Yes	2 XNo 3 □ Probably 4 □ Unknown
Ö	w req	plet	Thrombocytopenia		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Rec	The la ate ha page	Completed			performed?	death?
tal	cian: ertifica ector, I	Be (25. Was case referred to medical examiner?	26. Place of Death (Chec	k only one)	
Ξ	Physic this c	မ	1 Hospital: 1 Yes 2 X No		ome 5 Residence	
0 U	ding l h. After funer	ate	227. Wathrel 5 ☐ Pending (Month, Day, Year) 1 ☐ Natural 5 ☐ Pending (Month, Day, Year) injury	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how inju	ury occurred
Sio	Atten r deat ctor: by the	Certificate:	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, st			nd Number or Rural Route Number,
Division of Vital Records, P.O.	al or safter		building, etc. (Specify)		City or Town, Stat	re)
	lospit t hour unera ed fille	Medical	29a. Certifier 1 A Certifying Physician: To the best of my knowledge, death (Check 2 ☐ Medical Examiner: On the basis of examination and/or inve	occured at the time, date and place, a	nd due to the cause(s) a	and manner as stated.
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 Certifying furse Practioner: To the best of my knowledge. 29b. Signature and the of certifier	death occurred at the time, date and pla	ce, and due to the cause	e(s) and manner as stated.
	₽ ≥ ₽ ⊗		295. Signature and they in Confilling	29c. License number D0043351		eate signed (Month, Day, Year) $-28-2011$
)		30. Name and address of person who completed cause of death (Item 23a) (Type,			
					316, Gle	ndale, MD 20769
•	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Stinature 2. Apart	4		
	Registra	ar	MUYU 4 ZUII LOGUND P. LEGUNG			

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

		1 _ State	ryland / Depa	artment of Healt tificate of Deatl	h and M	lental Hy	giene	gible.	
Physicia Medic		1. Decedent's Name (First, Middle, Last) Joseph James	Davis	imeate of Beati		2. Date of De	er lay 2	01 ^Y ¶ ^{ar}	3. Time of Death 1:00 pM
Examin		4a. Facility Name (if not institution, give street and number) Somerford Place		4b. City, Town, or Location Columbia			4c. Coun Howar	ty of Death	_
Funeral Director		5. Social Security Number $ \begin{array}{ccccccccccccccccccccccccccccccccccc$	(In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under Months Days Hour	der 24 Hrs.	8. Date of Bir (Month, Da Jun 8,	1919	9. Birthp Count Texas	lace (State or Foreign ry) S
Maryland 28a-f shov	Funeral Director	10a. State 10b. County WV Jefferson	10c. City, Town or Loc Shepherds	town					0d. Inside City Limits 1 ☐ Yes 2 X No
with the s 23a or ust be r	eral D	10e. Street and Number 157 Fairmont Avenue		10f. Zip Code 25443			10g. Citizen of USA	f What Coun	try?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ▼ Divorced 12. Was Decedent Every Armed Forces? 1 ★ Yes 2 □ N (F yes, Give Year or Dates. 1	10	Was Decedent of Hispanic f Yes, specify Cuban, Mexi	ican, Puerto I	cify Yes or No- Rican, etc.)	Bla	ace - America ack, White, e	tc.
thin 72 hou sne. than "nat ne Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+	(Give I	lent's Usual Occupation kind of work done during m O NOT use retired)			16b. Kind of		
l be filed wi lental Hygic rked other tic event, ti	To Be (17. Father's Name (First, Middle, Last) John Newton Davis	Elect			(First, Middle,	Federal Maiden Surnar		Innenc
nd 2 should ealth and N n 27 is ma er traumal		19a. Informant's Name/Relationship (Type, Print) Kathleen Davis/daughter		g Address (Street and Nur Sperry Court				State, Zip C	ode)
Page 1 ar ment of He ant: If iter ury or oth		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	1	sition (Name of natory or other place) Lrney Cremato	1	oate /03/11	20c. Location Woodbi	-	
permit. Depart Import any inj		21. Signature of Funeral Service Licensee 2 Levely & Health 23a. Part 1. Enter the disease, or complications that caused to	G ² 0 MO1251 B∈	Name and Address of Fa Ling Home Cre verly L. Hec	emation ekrott	n Servi e, P.A.	ce P.C). Box	784 , MD 21029
be e	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of): ibrillatic consequence of): consequence of):	on					Approximate Interval Between Onset and Death
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of the pregnant at the pregnant	Fetal death 3	Ectopic pregnancy Other (specify)				ate of delive	ry Day Year
quires that the son signed by ould be deta		Part II. Other significant conditions contributing to death but Cellulitis	t not resulting in the u	nderlying cause given in Pa	art I.				e cause of death? ably 4 \square Unknown
sician: The law re certificate has be lirector, page 2 sho	Completed by					24a. Was autop perfo 1 Yes	osy ormed?		sy findings available inpletion of cause of
nysician nis certifi I director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 ER/Outpatien	26. Place of D			dence 6 🔀 Oti	a. her (Specify)	ssisted
ttending Pl death. tor: After th the funera	Certificate:	27. Manner of Death 1 🔀 Natural 5 🗆 Pending 2 🗀 Accident 1 Nestigation 3 🗀 Suicide 6 🗀 Could not be	Year) injury	28c. Injury at work? M 1 □ Yes 2	! □ No	8d. Describe h	now injury occur	rred	
oital or Ai ours after or oral Directilled in by		building, etc.				City or Tow			
the Hosp ithin 24 ho the Fune	Medical	29a. Certifier (Check check only one) 1	amination and/or invest	igation, in my opinion, death	h occurred at , date and pla	the time, date a ce, and due to t	ind place, and d he cause(s) and	ue to the cau manner as st	se(s) and manner stated. lated.
5 × 5 0		290. Signature and the of certified	m.D.	D56531	er		Novembe		
BXIV		30. Name and address of person who completed cause of dea Harry Li, M.D. 8600 Snowden	River Pkw		bia. N	⁄ID 2104	 5		
State Registra	-	31. Date filed (Month, Day, Year) NOV 0 4 2011 32/Registrar	s Signature	wed .					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dennis Physician/ Month 2:30 PM James Arthur a Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Director 1 M 2 □ F 10a. State 10b. County 10¢. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** or 28a-f sl 1 Yes 2 □ No ō 10g. Citizen of What Country? items 23a or ner must be r Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced lack Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) er than the Me Elementary/Secondary (0-12) College (1-4 or 5+) ulth and Mental Hygie 27 is marked other r traumatic event, th other Be 18 Mother's Name (First Middle Maide မ 19a. Informant's Name/Relationship (Type, Prin Day of See 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Health tem 27 20b. Place of Disposition (Name of cemetery, crematory or other p Method of Disposition **ĕ = ₀** 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signat re of Funera MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of g, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Metastati disease or condition resulting in death) 4.001 Medical ue to (or as a consequence of): Examiner Sequentially list conditions, Examiner Due to lor as a consequence of cause. Enter Underlying Cause (Disease or injury burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physici Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day been signed by the a should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year 3876 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sharon MO

DHMH 17 Rev 06-2011

Registrar

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11-07969 Aubrey Doyle Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Rubley Doyle		1- For State Registrar	Si	ate of iviarylan		tificate of		nu Menta		Reg. No. 201	1 3519
Physicia Medical Exami	an/	1. Decedent's Name	e (First, Middl	e,Last) Aubree	Nicolo	Doulo			2. Date of Dea Month October 2		3. Time of Death 1015 hrs
)				n, give street and numl				or Location of D		4c. County of Dea	
5		5. Social Security N			Age (In yrs. ia	ast hirthday)	Laurel If Under 1 Yo	ear If Under 2	4Hrs 8 Date of Bi	Prince Georg	
Funeral Director		305-91-	8704	1 M 2 F	Age (III yrs. Ie	Yrs.		ays Hours	Min.	Fore	
w any		10a. State	10b. County		10c. City,	Town or Locati	on				10d. Inside City Limits 1 Yes 2 X No
ryland n-f show t once.	ţ	MD 10e. Street and Nur		Arundel	Laur	rel	10f. Zip Code			10g. Citizen of What Co	
th the Maryland 23a or 28a-f sho notified at once.	Director			idge Way			20724			U.S.A.	,
ath with tems 23 st be no	Funeral	11. Marital Status 1 X Never Marrie		12. Was Deced	es?				(Specify Yes or No lerto Rican, etc.)	o- 14. Race - Ame White, etc.	erican Indian, Black,
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28s-7 sho natic event, the Medical Examiner must be notified at once.	by Fu	3 Widowed	4 Div	1 Yes orced If Yes, Give Year or Dates:	2 <u>X</u> No		Yes 2X			Specify: Wh	
036 thin 72 hours ne. than "naturi edical Exami		15. Decedent's Ed Elementary/Seco	• • •	cify only highest grade College (1-4				pation (Give kind fe. DO NOT use		16b. Kind of Business	s/Industry
0036 within 7 iene. or than Medica	Completed	0		SAIDE!		None				None	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be Co	17. Father's Name							lame (First, Middle, a Marie H		
21; hould b ad Men is mar	P	19a. Informant's Na	me/Relations	nip (Type, Print)		19b. Mailing	Address (Str	eet and Number	or Rural Route Nu	mber, City or Town, Sta	te, Zip Code)
∑ 2 d d d d d d d d d d d d d d d d d d	-	Jimmy L 20a. Method of Disp		le / fathe:	20b. F	Place of Disposi	tion (Name of o		Way, Laur Date	el, Marylan 20c. Location - City of	
timore, MD 2' The Pages I and 2 should then to of Health and M reast: If item 27 is may or other traumatice.		1 X Burial 2 (4 Donation 5		3 Removal from	State	crematory or oth		Pk O	ct 29, 11	Laurel, I	Marvland
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	Ì	21. Signature of Fu	neral Service	Liceus	10-	22. N Do	ame and Addre	ess of Facility n Funer	al Home,	P.A.	
Physician	-1	23a. Part I. Enter th	e disease, or	complications that cau	M007 sed the death.	773 3. Do not enter th	L3 Talb e mode of dyin	ott Ave g, such as card	 Laurel, acor respiratory an 	Maryland : rest, shock, or heart	Approximate Interval
Medical Examiner	Ì	failure. L(st/on Immediate Cause (or condition resulting	r Final disease	a. Sudden U Due to (or as a co			ath In	Infancy			Between Onset and Death
	۳	Sequentially list conif any, leading to im		b. Due to (or as a co	nsequence of	T):					
_	Wedical Examiner	(Disease or injury the events resulting in	rlying Cause hat initiated	c. Due to (or as a co	ensequence of	·):					
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x 687 h certific tending p		23b. Was decedent past 12 months	7	e 1 Live birtl	n t at time of dea	2 Fel	al death 3 ner (Specify)	B Ectopic pre	egnancy	Month	Day Year
that the deat ned by the at detached for	Phys	Part II. Other signi		ons contributing to d		esulting in the u	nderlying cause	given in Part I.	23e. Did t	tobacco use contribute t	o the cause of death?
s, P.O. ires that the signed by	d by								1 Ye	es 2 🗹 No 3 🗌 Pr	obably 4 Unknown
of Vital Records, ng Physician: The law require. Net this certificate has been simeral director, page 2 should t	Completed	_		_					24a. Was auto		
Vital Reysician: The his certifical director, pa	BeC	25. Was case referrexaminer?	red to medical				26.Pla	ce of Death (Ch	eck only one)		
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ion of tending Pheath.	ţį	1 Natural	5 Pend	(Month, D	ay,Year)	fd 9:26	∷ . ₁⊏	Yes 2 X No		• •	
Division spital or Attendi hours after death. neral Director: /	Certification	2 Accident 3 Suicide 4 Homicide	6 X Could	28e. Place of		me, farm, stree		building, etc.	28f. Location (or Town, Laurel	(Street and Number or F State) 3504 Riv	Rural Route Number, City er Bridge Way
D To the Hospital within 24 hours To the Funeral Completely filled	Medical Co	29a. Certifier	Certifying Ph Medical Exar	ysician: To the best on niner:On the basis of	f my knowledg examination ar	ge, death occur	red at the time, on, in my opini	date and place, on, death occur	and due to the cau	se(s) and manner as sta and place, and due to	ated. the cause(s)
To witi	Mec	29b. Signature and	title of certifie	and manner stat	ea.			nse number		29d. Date signed (M	
		Mli	- Gr	assell, M.	of death (II-	220)	0.0	C.M.E.		October 24, 20	11
X		30. Name/and address Melissa Bra		who completed cause Assistant Medi	cal Examin	er 900 W	. Baltimore	Street, Balti	more, MD 212	23	
St Regist		31. Date filed (Mont	th, Pay Year)	32. Regi	strar' Signatu	ares	,				

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ November 2011 10:45 A.^M Janice Claire Dvorak Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore 2-D Smeton Place Towson Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Hours Days 212-40-6850 Director 1 □ M 2 🕅 F Maryland 69 June 16,1942 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No <u>Maryland</u> **Baltimore** Towson or 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 23a 21204 U.S.A. 2-D Smeton Place or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 years Banking Loan Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Galley Martin Rudy Zorka Kuhn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau (husband) 2-D Smeton Place Towson, Maryland 21204 Gerard A. Dvorak 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus Cem. 11-7-11 Baltimore, Maryland 21. Signature of Funeral Service Licensee 2 Name and Address of Facility Mitchell-Wiedefeld Funeral Home, In 6500 York Road Baltimore, Maryland 21212 Part 1. Wer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Menin Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 n Day Month Year Pregnant at time of death 1 Yes 2 9 Unknown Division of Vital Records, P.O. Part II. Ot, e significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No injury Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. clical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Typing Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and t no completed cause Name (Item 23a) and address o SUME 302 TowsonMD 21200 31. Date filed (Month, Day, Year) State NOV Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) Physician/ October 21, 2011 1:21 PM M <u> Milton Rockwood Daniels</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1216 Havenwood Road Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, **Funeral** Days Months Hours **Director** 1 👿 M 2 🗆 F Feb 5, 1923 219-18-7430 Connecticut 88 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f sho Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ¥ Yes 2 ☐ No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21218 1216 Havenwood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? Black, White, etc. ģ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify white Completed 3 Widowed 4 Divorced if Health and Mental Hygiene. item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) US Coast Guard boat inspector 12 Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) မ Sally Jackson Milton R. Daniels Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1216 Havenwood Road Baltimore, MD 21218 19a. Informant's Name/Relationship (Type, Print) Stewart J. Daniels/brother 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🎗 Other (Specify) in state প্রথমধন্ত Attatomy Board 655 W. Baltimore Street Signature Robald Service Sicenswate, Director Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset a Immediate Cause (Final Ph_{sician/} disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence Exam eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? s after death, I Director: After this certificate 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\text{Nursing Home} \) 1 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No ပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 Yes 2 No iniury 1 Natural 5 Pending Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a To the Funeral C Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature 29c. License number 0020650 2011

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Durid D. Collins mD 6701 N. Charles St., Smitz 4101, Taltinure, MD

32. Registrar's Signature

NOV 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Betty Isabel Eckert Physician/ November 5:15 А м 2019 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Aberdeen **Examiner** 4c. County of Death d Dacota Assisted Living 5. Social Security Numbe 183-12-6480 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Birthp. OH **Funeral** 1 M 2 X F Months Days Hours Min. 09/06/1919 92 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified any once. 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Harve de Grace MD Harford X□ Yes 2 □ No 10f. Zip Code 21078 10e. Street and Number 109. Citizen of What Country? **Funeral** 119 Bluebill Court USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐XNo Specify. Specify. White Completed 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Be 18. Mother's Name (First, Middle, Maiden Surname) Katharyn Hoffman 17. Father's Name (First, Middle, Last) 2 James Carvell 19a, Informant's Name/Relationship (*Type, Print*) Edgar James Eckert / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, 119 Bluebill Court, Harve de Grace, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Chesapeake Crematory 1 \square Burial 2 X Cremation 3 \square Removal from State 11/3/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Forestal Service LicenseeDorota, Marshall Name and Address of Facility Mary Land Cremation Services 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween nset and Death Immediate Cause (Final 2 V 2 6 Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Day Year 1 Yes 2 1 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medica examiner? B B 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 🗙 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1. Natural 2 Accider (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined building, etc. (Specify) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu 29c. License number oven ber 2011 ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Haure De bree

2027 Pulasti

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last). 2. Date of Death Time of Death 45 Physician/ Calvin (Ctober aniel 209 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Luch Kaven Community Living 2UTEV Baltimore Social Security Number Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days 218-14-8098 1 🕅 M 2 🗆 F Hours 1270671923 87 Director Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1000 Hignet Way 21205 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces' Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced If Yes, Give Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tool and Die Maker Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Daniel Funk Veronica Gierczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daniel Funk- Son 1000 Hignet Way Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem 11/3/2011 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Signature of Funeral Service Licensee 6415 Belair Rd. Baltimore, MD 21206 23a. Part 1. Enter disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ructive ulmonary 115295e Onset and Death Immediate Cause (Final Physician/ hronic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death). Examine Due to (or as a consequence of): g physician and ts the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by MRSS Lung 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? Certificate: To the

the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 s after death. completed filled in by

			1 L Yes 2 L No						
5. Was case referred to medical		26. Place of Death (Che							
examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify)								
7. Many r of Death 1 V Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1	28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	actory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
(Check 2 Medical Exam	sician: To the best of my knowledge, death occur iner: On the basis of examination and/or investigations se Practioner: To the best of my knowledge, death	on, in my opinion, death occurred	at the time, date and place, and due to the cause(s) and manner stated						
9b. Signature and title of certifier	With I M.D.	29c. license number 5	October 29, 2011						
GROVEL L. WI	completed cause of death (tem 23a) (Type, Print)	3980 Loch	ove Maryland 21218						
NOV 0 4 2011	32. Registrar's Signature		,						
	p. parker								

Registrar DHMH 17 Rev 7/2009

State

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:37 PM EUZABETH A. FINLEY Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** UNIVERSITY OF MARLAND NEDILAL CENTER BALTIMORE 8. Date of Birth (Month, Pay, Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) **Funeral** Hours Director 1 M 2 show 10d. Inside City Limits 10a. State 10b. County Town or Location death with the Maryland notified at **Funeral Director** Baltimore 1 Yes 2 No 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō ms 23a or must be n 21212 442 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces? 9 ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If then 27 is marked other than "natural", or any injury or other traumatic event, the <u>Medical Exami</u>s any injury or other traumatic event, the <u>Medical Exami</u>s Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Year or Dates Specify: Completed 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4 or 5+) Home To Be Mother's Name (First, Middle, Maiden Surname) Father's Name (First Middle, Last) Clemons larence 19a. Informant's Name/Relationship (Type, Print, (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto alala 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) 4 Donatign Funeral Service Lie 270 Fredhilton Pass Balto. MD 21329 ver the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. 23a. Part 1. Enter the dis shock of heart failu Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ FAILURE PESPIFATORY disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** 4 days PESPIRATORY DISTRESS if any, leading to immediate cause. Enter Underlying Physician/Medical Examine 4 days Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed PNEUMONIA burial-tran Due to (or as a consequence of): physician Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) 1 Yes 2 E be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2: autopsy performe Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 2 No 1 Manatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Matural iniury 5 \square Pending within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 L Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

Registrar DHMH 17 Rev 06-2011 only one)

29b. Signature and title of certifier

VAININI PATEL, MD 31. Date filed (Month, Day, Year,

NOV 0 4 2011

pamen fato No

KAMINI PATEL, MO

-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1265731483

BALTIMORE, ND

ZESIDENT

225 GREENE ST

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

2/201

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ 4:02 AM Regina Anna Getz November 4 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Oct 29, Months Days Hours Min Maryland Director 1 □ M 2 X F 218-14-0774 1924 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or than "natural", or items 23a or the Medical Examiner must be Funeral United States 21221 42 Wagner Ave. death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) MD Cup Packer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important; if item 27 is monany injury or other ೭ Albrecht James Klapka Bertha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Harveson /Daughter Reisterstown, MD 21136 212 Greenview Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 0.8 Nov 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland 2011 Chesapeake Crematory 21. Signature of Funeral Service Lice 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mydlodysplastic Physician/ disease or condition Medical resulting in death) Due to (as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (bries a consequence of if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No has To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident the Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 06-2011

29b. Signature

31. Date filed (Month,

Atitle of certifie

NOV O

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ES

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Cherles

29d. Date signed (Month, Day, Year)

ST Pawon MM

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35206 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Annabelle G. Green 2:00P. 2011 October 0 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Senator Bob Hooper House
5. Social Security Number | 6. Sex | 17. Ac Harford BelAir If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) 219-16-4676 **Director** 1 □ M 2 😾 F 88 Yrs August 29,1923 Maryland Usual Residence of Deceder ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 □ Yes 2 🛚 No BelAir Harford Md. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21014 Apt. 224 <u>555 South Atwood Road</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married þ Yes 2 🗙 No Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 💢 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry
Baltimore City 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Public School Assistant Accountant and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bertha B. Nelson permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev ၉ Robert E. Gettier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1414 Tayside Way BelAir, Md. 21015 Nancy McKivrigan DTR. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1X Burial 2 Cremation 3 Removal from State Presbyterian 11-3-2011 White Hall, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home, Inc. Signanue of Funeral Service Licensee palle Nottingham, Md. 21014 610 W. MacPhail Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EPSI Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-tran and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical 38 IE FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform after death.

Director: After this certificate I Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 XNo 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Crobel 30, 201

O. Box 68760 Baltimore, Maryland 21215-0036 Baltimore, Maryland 21215-0036

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			Registrar 1. Decedent's Name (First, Middle,	Last)		Ochanic	ale or b	-Outil	2. Date of Dea		+++	3. Time of Death
	Physicia		Vanessa Grant						nother.	r 28,5	2011	2:35 PM
	Medic Examin		4a. Facility Name (if not institution,	give street and number)		4b. (City, Town, or	Location of Death		4c. Count	y of Death	
أتسب			Doctor's Commu					ham				orge's
	Funeral Director		5. Social Security Number 579-72-7568 Usual Residence of Decedent	6. Sex 1 ☐ M 2 😾 F	e (In yrs. last birth	rs. If U	Inder 1 Year ths Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Jan 24	Year)	Com	place (State or Foreign ntry) ington DC
	and show at	l. I	10a. State 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	Maryla 18a-f	Director	MD Montgo	mery	Silv	er Spi	ring					1 ☐ Yes 2 💢 No
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	h with ns 23 must	Funeral	424 Legato Ter					0901	" V N	US		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than "natural", or items 23a or 28a-f show amportant: If item 27 is marked other than any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 🙀 Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	ed 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.			ecedent of Hi specify Cuba es 2 💢 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)		ack, White,	can Indian, etc. lack
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au	be file ental l ked o ic eve	To I	Herbert Warr						1 Grant		,	
ary	hould and M s mar umat		19a. Informant's Name/Relationshi	p (Type, Print)	19b.	Mailing Add	dress (Street a	and Number or Rui	al Route Number	; City or Town,	State, Zip	Code)
Σ	nd 2 si salth a n 27 i er tra		Katina Harring	ton/daughter	1.	500 B1	ightse	eat #102	Landove	c, MD 2	0/85 ——	
Baltimore,	bage 1 ar		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☑ Other (Sp	3 □ Removal from State Decify) in state			(Name of or other plac	e)	Date	20c. Location	- City or T	Town, State
Balti	permit. P Departin Importa any inju once,		21. Signature Filheral Spice Li					tomy Boar MD 2120		. Balti	more	Street
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7	Medical Examiner		resulting in death)	Due to (or as a	a consequence o	nf):		iciena		•		-
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Box 68760	ath certificate be executed attending physician and for use as the burial-transit	by Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Fetal death		opic pregnance er (specify)	ey .		1	Date of deli Month	very Day Year
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ls, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. Within 24 hours after death. The transition of the function after this certificate has been signed by the attending physici for the Functal Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but to the funeral director, page 2 should be detached for use as the but the funeral director.	ed by P	Part II. Other significant condition	ns contributing to death b	out not resulting i	n the underl	ying cause giv	ven in Part I.				the cause of death? obably 4 Hunknown
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/ita	sicial certi	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 ER/Ou	tnationt 3	0.11	or,	lome 5 Resid	tence 6 🗆 O	ther (Speci	(fy)
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Division of Vital Records,	To the Hospital or Attending Physician: The k within 24 hours after death. To the Funeral Director: After this certificate h completed filled in by the funeral director, page	Certificate:	3 Suicide 6 Could r 4 Homicide determi	not be 280 Place of Init		rm, street, fa			28f. Location (S City or Tow		ber or Rur	ral Route Number,
Ω	Hospital 24 hours Funeral eted filled	Medical	(Check 2 Medical Ex	Physician: To the best of xaminer: On the basis of e Nurse Practioner: To the	xamination and/c	r investigatio	on, in my opinio	on, death occurred	at the time, date a	nd place, and	due to the o	cause(s) and manner stated.
	To the vithin To the somple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nuise Fractioner: to the	Dest of Hig Know	euge, death	29c. License	e number	ace, and due to the	29d. Date sign	ned (Month	, Day, Year)
			> fase	Arem	u		06	5909		10/	31/11	,
	•		29b. Signature and title of certifier Fasi I A I emu 31. Date filed (Month, Day, Year) NOV 0 4 201	who completed cause of d	leath (Item 23a) (Type, Print)	ack	2d. (a	nham	mi). 7	0706
	Sta	te	31. Date filed (Month, Day, Year) NOV 0 4 201	32. Registra	ar's dignatura	Re	<u> </u>	100				-
	Registr	ar	NOV U 4 201	Legent	, ,,	_						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35208 Certificate of Death Reg. No. 2. Date of Death
Month
Seven 1. Decedent's Name (First, Middle, Last) 3. Time of Death actober 6'81 PM raham ames a. Facility Name (if not institution, give street and number)
6000 d Samaritan Hospital 4b. City, Town, or Location of Death Balthmore at Baltmore Birthplace (State or Foreign Country) If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 217-58-9942 1 X M 2 - F Oct 15, 1953 Maryland 58 Usual Residence of Deceder 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 Yes 2 TNo MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2529 Perring Manor Road 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: black If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) state of MD correctional officer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Millie Washington Vernon West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2529 Perring Manor Road Baltimore, MD 21234 19a. Informant's Name/Relationship (Type, Print) Marilyn Graham/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) State MANUTUMY Board 655 W. Baltimore Street of Every 1 of Every Director 21201 Baltimore, MD Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Diabetes resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):

Physician/ Medical Examiner

Physician/

Medical

Examiner

Funeral

Director

ems 23a or 28a-f show r must be notified at 28a-f show

Director

Funeral

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Completed

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and I for use as the burial-transit been signed by the a should be detached cate has page 2 s within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director,

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

29b. Signature and title of certifie

	d										
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	. Was decedent pregnant in the past 12 months? 1 Yes 2 No										
	contributing to death but not resulting in the underlying cause given in Part I.										
morbid ob	esty	1 Yes 2 No 3 Probably 4 Whithown									
	J	24a. Was an autopsy findings available prior to completion of cause of death? 1 \(\sum_{\text{NS}} \text{ 2 \sum_{\text{NO}}} \) 1 \(\sum_{\text{NS}} \text{ 2 \sum_{\text{NO}}} \) 1 \(\sum_{\text{NS}} \text{ 2 \sum_{\text{NO}}} \)									
25. Was case referred to medical	26. Place of Death	n (Check only one)									
examiner? 1 Yes 2 400	Hospital:	rsing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28d. Describe how injury occurred									
3 Suicide 6 Could not 4 Homicide determined	1 38a Place of Injunt. At home farm street factory office	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
(Check 2 Medical Exan	ysician: To the best of my knowledge, death occurred at the time, date and painer: On the basis of examination and/or investigation, in my opinion, death occ	curred at the time, date and place, and due to the cause(s) and manner stated.									

29c. License numbe H0068996

Raven Berd

29d Date signed (Month, Day, Year) Seven

saltmore mo

State Registrar

ted ause of death (Item 23a) (Type, Print)

5601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 7:00 AM Mary L. Goloway 2011 DOTOBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE Towson SAINT JOSEPH MEDICAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Director 212-32-1125 1 🗆 M 2 🗶 F Dec 23, 1934 California 76 28a-f shov 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 X No Baltimore Baltimore ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 35 Eastford Court 21234 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. . Or Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: white Specify: "natural", 3 ☐ Widowed 4X Divorced Year or Dates injury or other traumatic event, the Medical unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) $\overset{\text{College (1-4 or 5+)}}{2}$ 12 project assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ann M. Pushman Roy T. Pyrene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 21 Fairview Avenue #427 Tuckahoe, NY 10707 Anne J. Goloway/daughter Department of Health Important: If item 27 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) Signature of Egneral Service Licenses Ronal d State and Address of Facility and 655 W. Baltimore Street inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heary failure. List only one cause on each line. 23a. Part 1. shock, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE GASTROIN TESTINAL disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): physician and s the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph I for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death 2 No 1 ☐ Yes ∠ g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No ည 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral C completely filled Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certif 0015452 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7601 TOWSON, MARYLAND TIMOTHY BESSENT OSLER DRIVE

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ '00 AM ARI Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Director 1 🗆 M 2 🔯 F TRANC 28a-f show 10h Counts 10d. Inside City Limits 10c. City, Town or Location must be notified at Director 1 Yes 2 No ò 10g. Citizen of What Country? Funeral 23a dening and 2 should be filed within 72 hours after death w Health and Mental Hygiene. tem 27 is marked other than "natural", or items ther traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ♠No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Newell Ruberm College (1-4 or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ NOWN 19a. Informant's Name/Relationship (Type, Prospand Daughte) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ■ Burial 2 ☐ Cremation 3 ☐ Removal from State East Point, 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Dicent 22. Name and Address of Facility W. Oab Row She LOJESH DUNGS Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical O that the death certificate be Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown Division of Vital Records, P.O. signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed? death? 2 No Yes 2 N Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 D No မ 4 Nursing Home 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred 1 D Natural 5 Pending Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical 1 🔾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print alto,

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Mo.

11-08182	
Tseng-Yi Hsiao	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

seng-Yi Hsiao		1- For State	ate of Maryla		artment of		and	Menta	al Hy		eg. No. 2	0 1	1 35	21
Physicia		Registrar 1. Decedent's Name (First, Midd	le,Last)						2	2. Date of Dea	th	ear	3. Time of Death	
/ledical Exami		Tseng-Yi Hsia		_						Novembe	r 1, 2011		0515 hrs	
		4a. Facility Name (if not institution 401 West Pratt Street)		ımber)	41	. City, Tow Baltimo		ocation of	Death		4c. County	of Death		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1	Year	If Under	24Hrs.	8. Date of Bir	th (MM/DD/YYY		thplace (State or	
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	ŀ	Usual Residence of Decedent							1					
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_	Funeral Director		51.27a1.20mi7/2 車登 6. Sex 127-725-6758 1 □ M Usual Residence of Decedent	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea 9 / 14 / 20	71921 1-1	Cour	place (State or Foreign htry) bama
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the Hospi	To the Funeral Dire completely filled in b	Medical	29a. Certifier (Check only one) 3 Certifying Physician (Check only one) 3 Certifying Nurse Pra	On the basis of examination	on and/or investi	gation, in my opinior	n, death occurred at	the time, date and pla	ace, and du	e to the ca	use(s) and manner stated.
To 1	000		29b. Signature and title of certifier	Mh-	30	29c. License			Date signed		
51			30. Name and address of person who compl	eted cause of death (Iter	m 23a) (Type, Pr	int) Blu	of all	n Burn	ip 2	2/0	06/
	Stat Registra	•	31. Date filed (NOV) 94 2011	32. Registrar's Sign	bark	w	47.0				<i>i</i> =

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month orber 12-50 PM Henson <u>J.</u> Medical Sarah 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deat Examiner nna Glen Burnie Baltimore-Washington Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Jan. 24,1923 Kentucky 219-32-1140 88 Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö Examiner must be Funeral items 23a U.S.A. 21061 503 Morningside Drive hours after death 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 1 Never Married 2 Married Ď Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Fruit & Vegetable Co. Packer N/ABe 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mobley permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic & once. Martha William Hardy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1451 Old Fort Smallwood Road Pasadena, Maryland 2112 Fontella Bateman (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 11/05/2011 Elkridge, Maryland Meadowridge Mem. Pk. 4 Donation 5 Other (Specify) 22. Name and Address of Facility
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21. Signature of Funeral Service Licenses 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or iinjury that initiated events and Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death ertificate be 68760 din IF FEMALE se 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ been signed by the attershould be detached for in the past 12 months? Day Pregnant at time of death 1 Yes 2 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performe has certificate Yes **Division of Vital** or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ြုင 1 Ninpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No n 24 hours after death.

e Funeral Director: Aft bleted filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. pleted only one 29b. Signature and title of certife Glem Burnie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOM OWUSM State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🙀 F Director <u> 213-76-7517</u> 53 9-19-1958 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene.

The state of the state of the stan "natural", or items 23a or 28a-f show and: if item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location notified at 1 Yes 2 No Directo MD Baltimore Dundalk 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code ed other than "natural", or items 23a o event, the Medical Examiner must be 243 Baltimore Avenue Funeral 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ğ Specify: White 1 Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Own_Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Elwood Hill, II 2 Ida Parlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ida Hill - Mother 243 Baltimore Ave., Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11-4-11 Baltimore, MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility Bradley-Ashton Funeral Home PA, 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on e ch line Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any hading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to jor as a consequence of or Attending Physician: The law requires that the death certificate be executed g physician and as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) d by the ar 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 4X Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 2 🗌 No certificate 1 Yes 1 Yes 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \square Residence 2 🗌 No 1 \square Inpatient 2 FR/Outpatient 3 DOA ၉ 6 Other (Specify) 28a. Date of Injury this filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending investigation after death, Director: Af 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral Hospital 29a. Certifier (check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 00069427 November 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pham Kremanh 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Month, Day, Year) 32. Registrar's Si State NOV 0 4 2011 barker Registrar

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 10 Physician/ Suzanne L. Holland 2011 52 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WICOMICO lisburu 0 at Age (In yrs. last birthday) If Under 24 rs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Months July 28, 1 □ M 2 👿 F Arizona 175-26-2041 63 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No MD Wicomico Salisbury 10f, Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 875 Victoria Park Drive #111 21801 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: white If Yes, Give Year or Dates 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) marketing staffing specialist and Mental Hygien is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Grace Viola Schweikert Edmund Levi Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 27970 Cross Creek Drive Salisbury, MD 21801 Lauren Ruhl/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Sign lare of Funeral Service ²² State Anatomy Board 655 W. Baltimore Street S/ Wades Director Raltimore, MD Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final . h sician/ disease or condition resulting in death) Canec Medical Due to (or s a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Due to (or as a consequence of): Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 attending place as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death n signed by the a ld be detached f 9 Unknown Unknown P.O. E Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: Ž√ No 4 Nursing Home 5 Residence 6 Other (Specify) H O မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? alc Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 063199 ss of person who completed cause of death (Item 23a) (Type, Print) EASTERN

State Registrar

SHORE DR. SALISBURY

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2. Registrar's Sign

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) George Deloch 2. Date of Death 3. Time of Death Hinton Physician/ Month 10/25 6:15am Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth ocial Security Number 246–38–4488 **Funeral** Month, Day, Year) 11/5/1930 Hours Min 80 **Director** 1**3€3**M 2 □ F NC 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director NC Nash Rocky Mount 1 XXes 2 No ō 10e. Street and Number 716 Star Street 10f. Zip Code 10g. Citizen of What Country? 27804 23a Funeral USA death "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? → XXYes 2 □ No Ur. If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Unk Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 Divorced Completed traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Manufacturing Laborer Be 17. Father's Name (First, Middle, Joseph 18. Mother's Name (First, Middle, Maiden Surname Hinton Arabella Battle 2 1 and 2 should to the street and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Hines / Daughter 889 Ellison Drive, Rocky Mount NC 27801 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 Department of I Important: If its any injury or of 1 Burial 2 Cremation 3 Removal from State Gardens of Gethsemane Cemetery 10/30/11, Rocky Mt, NC 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee VICLOR P. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 ارير 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury and -trar that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death detached the Unknown 9 Unknown P.O. signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? cate has l 2 No this certificate 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No မ 1 Linpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer Natural 5 Pending 1 Yes 2 No hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title AAME 2001

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

(Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JOHNSON ENCE Medical Facility Name (if not institution, give street and number) **Examiner** City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. Hours Min. Funeral 8. Date of Birth 9. Birthplace (State or Foreign Sex. 1 M M 2 □ F Months Days 01/05/1926 South Carolina Director Usual Residence of Decedent or 28a-f show an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits MD N/A Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? 6039 Falkirk Road 21239 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🛮 No Specify: 3 Nidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) ntal Hygiene. Truck Driver Milling Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fred Johnson Francis Workman Briggs Julo Jand Mering 17 is in Department of Health and Men Important: If item 27 is mar e any injury or other traumati and 2 should of Health and Meritem 27 is man 19a. Informant's Name/Relationship (Type Print) Mary Lee Johnson Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2502 Eutaw Place Apt 400 Baltimore, MD 21217 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 X Removal from State Jersey Cemetery 11/8/2011 Laurens, SC 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. muhael 6009 Harford Road Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph_sician/ Dementia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical as IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Descript at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Yes 2 No 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of performed? Yes 2 \(\sigma\) N To the Hospital or Attending Physician: The death? this certificate 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? 2 No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Il Director: After this ed in by the funeral o Manger of Deat Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work?
1 Yes 2 No 5 Pending injury Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cert rson who completed cause of death (Item 23a) (Type, Print) 3900 Loch Raven State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Examin		4a. Facility Name (if not institu	. 1		1.1	.,	1	1 .		Location	of Death		- 1	c. County		
Funeral	_	5. Social Security Number 229-90-3807	105 6. Se	pkins)501 e (In yrs. Ia	ast birthday)	If Unde	timo r 1 Year	If Under		8. Date of Bi	rth			place (State or Foreign
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and 2 s Health em 27 ther tr		Janette Jac 20a. Method of Disposition	kson	-Sist	er	20h P	2480			St.		Ltimor Date	_			own, State
Page 1 nent of int: If it iry or o		1 Donation 5 Oth			n State	C	emetery, cre	matory or	other plac			/2011		Ltimo	-	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Serv	ce Licens	see	7		2	2. Name a	nd Addres	s of Facili	ty Ma	rch F/	H]	101	Ε.	North
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bu		29a. Certifier 1 N Certif	ying Phys	sician: To the	best of	my knowl	edge, death	occurred a	at the time	e, date and	d place, a	nd due to the	cause(s)	and mann	er as sta	ted.
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7 wit		29b. Signature and title of cer	inter A					D 29	c. License	number				ate signed		
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	ToE	17. Father's Name (First, Middle, Last) JACK ALVIN B	INDON		18. Mother's Nam CORRINE		Maiden Surname) (WAI	RD)
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Baltimo permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licensee		22. Name and Addres				NERAL HOME MD 21237
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Invision of Vital Records, F.C. Box 08/00 To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical C	29a. Certifier 1 Certifying Physician: To the bes	st of my knowledge, c	death occurred at the time	, date and place, a	nd due to the cau	use(s) and manner as s	stated.
the Ho thin 24 the Fu mplete	Med	(Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practitioner:		vledge, death occurred at the	ne time, date and pla	ace, and due to the	e cause(s) and manner	as stated.
5 <u>№ 6</u> <u>6</u>		29b. Signature and title of certifier		29c. License			9d. Date signed (Mont	
		30. Name and address of person who completed cause	of death (Item 23a) (T	Type, Print)	0000		11-1-0	VII
Sta	ate.	Dr Brandon Perry 31. Date filed (Month, Day, Year) 82. Rec	9 000 F	ranklin Sc	juare Dr	ive Ba	1timose	MP 21237
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ORIGINAL

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	Funeral		,	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da Dec 13	h y, Year) 9. B	irthplace (State or Foreign Country) nnecticut
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	yland how		10a. State 10b. County		10c. C	ity, Town or Loc	cation				10d. Inside City Limits
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yland	uld be Mental Irked o	To Be						Acolia	Jouner		
Mar	alth and 2 sho alth and 27 is me		19a. Informant's Name/Relationsh Leslie Johnson			19b. Mailin 6324	g Address <i>(Street</i> Patters	and Number or Ru on Street	ural Route Numbe L Riverda	er, City or Town, State ale, MD 2	Zip Code) 0 7 3 7
baitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Inmportant: If time Z7 is marked other than "natural", or items Z3a or 28a-f show any Injury or other traumatic event, the Maclical Examination as be notified a once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (Sp		20b. n State state	Place of Dispos cemetery, crem	sition (Name of natory or other pla	ce)	Date	20c. Location - City of	or Town, State
Dalt	permit. Departn Importa any Inju		21 Si novare of Euneral Service I	icensee ade,	Directo	r ² 8	Name and Adda Baltimore	-	rd 655 W 201	. Baltimor	e Street
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	-xammer	<u>۲</u>	Sequentially list conditions, if any, leading to immediate	b. — Due to	o (or as a conse	nuence of):					
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ה ה	an and rial-tra	Exa	resulting in death) Last	c Due to	o (or as a consec	quence of):		· · · · · · · · · · · · · · · · · · ·			
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	ertifica ling ph	Med	IF FEMALE:	1							
ָם מ	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of pregn birth 2 ☐ Fet	al death 3 □	Ectopic pregnanc	у		23d. Date of o Month	delivery Day Year
5	y the ched	ysic	1 □ Yes 2 □ No 9 □ Unknown	9 ☐ Unk	gnant at time of known	death 5∟	Other (specify) _				
r.	e taw requires that the death certificate by the attending the 2 should be detached for use as		Part II. Other significant conditio	ns contributing to	death but not res	sulting in the un	derlying cause giv	en in Part I.	23e. Did to	obacco use contribute	to the cause of death?
ecords,	quires an sig uld be	ed by							1 🗆 1	res 2 No 3□	Probably 4 ☐ Unknown
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5	this o	2	1 Yes 2 100		Inpatient 2			4 Lanursing F		dence 6 Other (S	pecify)
SIOII	After funer	tion	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investig) (Mo.	e of Injury onth, Day, Year)	28b. Time of Injury	28c. Inju Wor M 1 🗆	ryat k?]Yes 2 □ No	28d. Describe i	now injury occurred	
2	r deat	fica	3 ☐ Suicide 6 ☐ Could n	ot be	e of Injury - At h	jome, farm, stre	et, factory, office	1100 2 2 110		Street and Number or	Rural Route Number,
5	ral or rs after al Dire	Certification:	4 Hornicide	1 ().					City or Tov		
	within the hospital or Autentium Prinystolan; The law requires that the beath certifine 24 bounds after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying (Check only one)	Examiner: On the	ne best of my kn basis of examin nner stated.	owledge, death ation and/or inv	occurred at the tivestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
į	To the common co	Σ	29b. Signature and title of certifier	10			29c. Licens	se number		29d. Date signed (Mo	
			,	Le		MD		058291		(0/27	
			30. Name and address of person v	who completed cau	use of death (Ite	m 23a) (Type, F	Print)	nE 01.2.	2 200	BILLISHA	E. ND 20737
	Sta	te	SURESHIKUMAN. 31. Date filed (Month, Day, Year)	MUTT /ATP	Registrar's Sign	ture	13 07 1 610	ac 2011 (= a00,	ILIO CKINA C	E > W.D 4019
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lattie King-McC	,oy	State of Maryland /	Department Certificate			Mental		201	1 2522
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last) Mattie E	rnestine		2. Date of Deat	eg. No. U th Day Year	3. Time of Death		
Medical Exami	ner	MATTIE E. KING	/ McCOY			ocation of De	October 2	7, 2011	0830 hrs
		4a. Facility Name (if not institution, give street and number) 4021 Wards Chapel Roa 4021 Ward Chapel Road	d 		rriottsville			Baltimore Cou	ınty
Funeral Director			(In yrs. last birthday	Mo	nder 1 Year oths Days	If Under 24I	1in.	th(MM/DD/YYYY) 9. Bir Foreig	n
		233 58 4043 1 M 2 F Usual Residence of Decedent	73	Yrs.			7/7/	38	wintry W.V.
v any		10a. State 10b. County 1	0c. City, Town or Lo	ocation					10d. Inside City Limits
Aaryland 28a-f show 1 at once,	tor	MD. CARROLL 10e. Street and Number	MAI		TTSVI	LLE	11	0g. Citizen of What Cou	1 Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once,	Director	4021 WARDS CHAPEL I		101.	2110	4	1"	USA	nuy!
with the ns 23a be noti		11. Marital Status 12. Was Decedent E			dent of Hisp	anic Origin? (Specify Yes or No	- 14. Race - Amer	ican Indian, Black,
r death	Funeral		No No				rto Rican, etc.)	White, etc.	V C.K.
rs afte ural",	<u>S</u>	Widowed 4 Divorced If Yes, Give Yeer or Dates: 15. Decedent's Education (Specify only highest grade comp	leted) 16a. Dece		2 X No	specify: on (Give kind	of work done	Specify: DIJ 16b. Kind of Business/	
72 hours n "natur	Completed	Elementary/Secondary (0-12) College (1-4 or 5+	durin			OO NOT use			
0036 within iene.	J mc	12	F	REDIS	STERE		RSE	NURSIN	G
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, the Medical Examiner must be notified at once	Be C	17. Father's Name (First, Middle, Last) JOHN LEE HULL			1	s.mothers Na LEO	me (First, Middle, M $A - HUL$]		
21; nould b id Men is mark	은	19a. Informant's Name/Relationship (Type, Print)	100		,	and Number	or Rural Route Num	nber, City or Town, State	
MD and 2 sho salth and em 27 is raumati		CHARLES McCOY 20a. Method of Disposition	20b. Place of Dis				EL RD.M.	ARRIOTTSV 20c. Location - City or	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	П	1 Burial 2 Cremation 3 Removal from State		or other pla	ce)		1/7/11	ARBUTUS	·
altir nit. Pa artmer sortani		4 Donation 5 Other Specify/ 21. Signature of Funeral Service Licensee		22. Name a	nd Address	of Facility			
E Per De Co		Count albun Telat			EUTA			OME P 4 MD 2121	
Physician		23a. Part I. Enter the disease, or complications that caused the failure. List only one cause on each line.						est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Car Due to (or as a conseq		sease C	omplicate	ed By Drov	vning		Deau
		Sequentially list conditions, b.							
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uted Id ansit	Еха	events resulting in death) Last Due to (or as a conseq d.	uence of):						
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ox 6876(eath certificate attending phys for use as the b	ΣI	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome	of pregnancy	Fetal dea	th 3	Ectopic pres	inancy	23d. Date of deliver Month	y Day Year
Box 6876 e death certificate the attending phy ed for use as the l	sicia	past 12 months? 4 Pregnant at tir 1 Yes 2 ✓ No 9 Unknown		Other (S	pecify)				
D. B.	Physicia	Part II. Other significant conditions contributing to death b	out not resulting in t	he underly	ing cause giv	ven in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Reco	E O						1 Yes	rmed? death? 2 No 1 ✔ Y	es 2 No
ital Recions: The sector, page	a	25. Was case referred to medical examiner? 1	2 ER/Outpat			of Death (Che		Residence 6 🗸 Othe	r. Seeme
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ion (tendin eath.	ation	1 Natural 5 Pending Pending Oct 27, 2011	FOUND: 0810 hrs		1 Ye	es 2 🗸 No	Subject four	nd submerged in b	pathtub
Division of Vital Records, ral or Attending Physician: The law requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be 28e. Place of Injur	ry - At home, farm, s	_	ory, office bu	_		Street and Number or Ru tate) hapel Road , Marriott	
E Con Di		4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my leading to the control of t	cnowledge, death of				' Wards	5	
To the Howithin 24 b To the Fun completely	edical	one) 2 Medical Examiner: On the basis of examinand manner stated.	_						
FFF5	ž	29b. Signature and title of certifier		1	29c. License			29d. Date signed (Mo	
		None and address of a second to	ath (Itom 225)		O.C.M	ı.c.		November 2, 20	11
5		 Name and address of person who completed cause of dea Donna M. Vincenti, MD Assistant Medica 		00 W. B	altimore	Street, Bal	timore, MD 21	223	
St Regist	ate	31. Date filed (Month Pay Year) 2011 32. Registrar's	Signature	ale					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35222 Certificate of Death Reg. NoZ U 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Year 54 AM Mary Bernadine King 2011 NOV 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Pital 405 (-00 d Samaritan 13altimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yea Apr 02, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year) Months Days Hours Min 1 □ M 2 🕱 F Maryland 213-26-4199 1929 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Baltimore 1 ☐ Yes 2 No Parkville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2218 Lowell Glen Rd. Condo D. 21234 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Bernard Hoff Kate Elizabeth Fox 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Dawson /Daughter 2261 Hughes Shop Rd. Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 04 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Noremaddren of andly Funeral Alternatives MO1585 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Mut 901 aus Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician /Medical Examiner

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Physician

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MD

Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exx., it with the undiffed an once.

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Baltimore, Maryland

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the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death.

Division of Vital Records, P.O. Box 68760,

Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn. 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a	al death 3 Ectopi	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Š	Part II. Other significant conditions of	contributing to death but not res	ulting in the underlying	g cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death? 2 No 3 Probably 4 Unknow 24b. Were autopsy findings available
To Be Completed	25. Was case referred to medical				autopsy performed	prior to completion of cause of
	examiner?	Hospital:	ER/Outpatient 3 🗆	Other	eath (Check only one) Home 5 Residence	ce 6 ☐ Other (Specify)
	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	
Medical Certification:	3 Suicide 6 Could not b determined	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)			
	29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best of my knominer: On the basis of examination and manner stated.	owledge, death occurr ation and/or investigat	red at the time, date and plain, in my opinion, death o	ace, and due to the caus courred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
	29b. Signature and title of certifier	MD	2	29c License number		Date signed (Month, Day, Year) O'Nem bev 2 201

5601 Loch Raven Blud, Ballimore MD 21239 Abou Zahr 31. Date filed (Month, Day, Year) egistrar's Signature NOV 0 4

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if npt institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Months Min. 5 Director or 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits Examiner must be notified 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral or items 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Yes Give 3 Divorced 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. Do NOT use retired) (Specify only highest grade completed) and Mental Hyglene. 9conday (0-12) College (1-4 or 5+) PARDEN TARTOW/ER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည or other traumatic 2RIGG 9 19a. Informant's Name/Relationship_s(Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State teg, crematory 1 ☐ Buria! 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 23a. Party. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or leart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Certificate: To Be Completed 1 Yes 2 No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has b lirector, page 2 sl autopsy 2 🗌 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 Tes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature a 29d. Date signed (Month, Day, Year) 18587 2011

◯ State

DHMH 17 Rev 7/2009

Registrar

cause of death (Item 23a) (Type, Print)

731 M

31. Date filed (Month, Day, Year)

NOV 0 4 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Paul KUNZ 9:104 Novembe 2011 Medical 4b. City, Town, or Location of Death Elkton 4a. Facility Name (if not institution, give street and number) **Examiner** 4c. County of Death 59 Mason Court Cecil 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 109-40-4965 **Director** 62 1**X** XM 2 □ F 01/13/1949 Austria Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director Elkton MD Cecil 1 Yes 2X No 10e. Street and Number 10f. Zip Code 21921 and Mortial Hygiene. Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 59 Mason Court 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2XXNo If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) **5+** 0i l Manager Be permit, Page 1 and 2 should be file Department of Health and Mental Humportant: If item 27 is marked of any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Katharina Meder Kunz Pau1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State 7th Code) Christian Kunz / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Atlantic Crematory or other place) 11/4/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) of Funeral Service LicenseDprota, Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Colorectal Ph_sician/ (uncer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or hijury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? After this certificate 1 ☐ Yes 2 ☐ No ours after death.

eral Director: After this certifical filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral L Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check MSRaj up And M.D 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

· Lajapa Ke, M'D

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Ballimore MO 21209.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 3Ï,201Ï Audrey Marie Krause October 4:50A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Balto. Oakcrest Village Care Center Parkville Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. July 6, 1918 Vrs **Director** Maryland 219-05-0483 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director Md Balto. Parkville Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8832 Walther Blvd. Rm. 308 21234 USA items 2 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 1 X Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 4:SDAN life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lochhead Martin 12th Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Krause Etta Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8600 LaSalle Road Suite 320 Towson, Md. 21286 Matthew Lidinsky Atty. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Oaklawn Cemetery 11-4-2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 21. Signature of Funeral Service Licensee Miller-Dippel Funeral Home, Inc. 22. Name and Address of Facility 6415 Belair Road Baltimore, Md. 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ardionyopati disease or condition Medical resulting in death) Due to (or as a counquence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transi Cause (Disease or imjury that initiated events Y COUST and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month detached for Month Day Year Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform eral Director: After this certificate I filled in by the funeral director, page 2 No 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 No hours after death Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completed filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R171944 aux, MSH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michealle G. Harrison CRIP MSN 8807) W CRIP MSN 8800 Walther Blvd, Parkville, MO 21234

DHMH 17 Rev 7/2009

State Registrar 32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35226 Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 1022 AM Month Physician/ HGAZOZ KAMARA ABU Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SILVER CROSS SPRING MONTGONERY HOSPITA Social Security Numbe If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min (Month, Dav. Year) Country) 1 M 2 D F **Director** 04 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Funeral Director MD 1 Yes 2 No PG.CO MAHUA-10e. Street and Numbe 6 10f. Zip Code 10g. Citizen of What Country? must be 23a GOOD LUCKRD USA 2040 items be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian. Medical Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married ò þ Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify If Yes, Give Year or Dates Specify: "natural", 3 Widowed 4 Divorced Completed BLACK 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) the INFANT MARANI Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ည ABUBAKAR traumatic KAMARA MUMMY KAMARA Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trauonce. SILVER SPRING MD 20910 CROSS HOSPITAL 1500 FOREST GLEN RD HOLY Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1
Burial 2 Cremation 3 Removal from State 4 □ Donation 5 \ Other (Specify) in state Ponal S Wade State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Approximate Interval Between Onset and Death - Physician PREMATURITY - 20 WK GESTATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 00 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, INCOMPETENT CERVI 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No After this certificate has completely filled in by the funeral director, page 2 death?

1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation 6
Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 29c. License number

State

Registrar

NANCY

31. Date filed (Month, Day, Year)

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MD

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	Physicia Medic		1. Decedent's Name (First, Middle, Last	heller	n Kelle —	r Jr.		2. Date of De Month	0-27	-11 Year	3. Time of Death
, see	Examir		4a. Facility Name (if not institution, gives Upper Ches aperte M	etreet and number)		4b. City, Town, or	Location of Death	-	4c.	County of Deat	1
	°Funeral Director		Social Security Number 6. Se		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year)	9. Bir Co	thplace (State or Foreign untry)
	3	٦	Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Loca	tion _		0/.22	2/30		10d. Inside City Limits
1	the Maryland or 28a-f show e notified at	irecto	PA Montgo			Orel	.and 				1xxXYes 2 ☐ No
II/TC/01	s 23a or	Funeral Director	10e. Street and Number 2002 Lodges La	ne		10f. Zip Code 1	9075		10g. Cit	tizen of What Co	USA
000	permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1 ☐ Never Married ※※ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates.	lf `	as Decedent of H /es, specify Cuba	ispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit Specify:	
15-0	72 hour in "natu Medical	Completed by	15. Decedent's Ed (Specify only highest grad	de completed)	(Give kii	nt's Usual Occup nd of work done o NOT use retired)	during most of work	king	16b. K	ind of Business	Industry
1212	d within lygiene. ther tha	Be Col	Elementary/Seconday (0-12)	College (1-4 or 5+)			s Police			College	
12 /land	d be file Mental H arked of	To B	17. Father's Name (First, Middle, Last) Clifton Ke	ller, Sr.			18. Mother's Nan Julia	Mitché	Maiden	Surname)	
Baltimore, Maryland 21215-0036	nd 2 should ealth and N n 27 is ma er trauma	-	19a. Informant's Name/Relationship (Ty) Gail Keller	ge, Print) Wife	19b. Mailing 2002	Address (Street Lodges	and Number or Rui Lane Ore	eland PA	er, City or	Town, State, Zi 9075	p Code)
TUD	Page 1 ar ment of He ant: If iter ury or oth		20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 🔀 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposi cemetery crema 7 H111	tion (Name of utory or other place remator	ğ 11/7,	Date / 2011	l	ocation - City or Ladelphi	
Bait	permit. Depart Import any inj	1	21. Signature of Funeral Service License	• Victor Doda	²² Ch	Name and Addre Darles L	ss of Facility • Stevens rt Avenue	Funera	l Ho	me, Inc	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	lications that caused the deat e cause on each line.						1111-2-12-	Approximate Interval Between Onset and Death
	Physician/ Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. CCCCAT	Ince of):	ry dis	EASE				Unset and Death
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of):						
Cic	executed an and rial-trans	I Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequ	uence of):						
CIIFH x 68760	icate be physici s the bu	ledica		d							
7, CIIF.	Attending Physician: The law requires that the death certificate be executed *r death. *ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Fett 4 Pregnant at time of a 9 Unknown	al death 3 🔲	Ectopic pregnand Other (specify)	су		0	23d. Date of de Month	elivery Day Year
2//t , P.O	es that thighed by	by Pt	Part II. Other significant conditions co	ntributing to death but not res	sulting in the un	derlying cause gi	ven in Part I.				o the cause of death? Probably 4 Unknown
ords	sician: The law requires t s certificate has been sign lirector, page 2 should be	oleted	Hypertensicu					24a. Was	an	24b. Were au	utopsy findings available completion of cause of
SS Rec	The lay cate hay	Com							ormed?	death?	es 2 No
34. Vital	ysician s certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ER/Outpatient	Oth	er: 4 Nursing H		idence 6	6 ☐ Othe <u>r (Spe</u>	
CLOSHSS on of Vital Red	ding Phy h. After thi funeral	ate: 1	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injur worl	y at	28d. Describe			
1800 LOS 488 1/2 Division of Vital Records,	spital or Attending Physician: ours after death. neral Director: After this certific filled in by the funeral director,	Certific	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stree		ries 2 🗆 No	28f. Location (City or To			ural Route Number,
10	To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A completed filled in by the fu	Medical Certificate:	(Check 2 Medical Examir	ician: To the best of my know her: On the basis of examinatio e Practioner: To the best of m	n and/or investig	gation, in my opini	on, death occurred	at the time, date	and place	e, and due to the	cause(s) and manner stated.
104	To the within comp	_	29b. Signature and title of enlifier	MA Amo		29c. Licens		>		ate signed (Mon	
	•		30. Name and address of person who co		n 23a) (Type, Pri	nt)	06972			27/20	11
-16	_04-		DANIEL HOINY 31. Date filed (Month Day Year)	AL SOO Signal	Inper (Lesaper	a Dr.	Bel Ai	<u> </u>	nD	
	Sta Registr		31. Date filed (Month Day, Year) 4 20	11 Lives	B. 130	exhal					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 9:50 A M Audrey Lautenberger Melinda November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick 4548 Cherry Lane Jefferson 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) If Under Social Security Numb Year **Funeral** Months Hours Min. (Month, Day, Yea Maryland 1 🗆 M 2 🔀 F Director 221-46-2307 Sept 56 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10c, City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2X No MD Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21755 4548 Cherry Lane 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🌠 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 f Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Financial Analyst Aerospace 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Doris Leona Ambrose Kenneth Stanford Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4548 Cherry Lane Jefferson, MD 21755 James A. Lautenberger/husband other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Final Journey Crematory 11/4/11 20a, Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Durial 2 X Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Going home cremation Service P.O. Box 784 MD 21029 Clarksville. MO1251 Reverly L. Heckrotte, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ years a Metastatic Breast Cancer disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events tran-Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Year Month Day 1 Yes 2X No g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be Brain Metastases 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? To the Hospital or Attending Physician: The ☐ Yes 2☐ No 1 ☐ Yes 2 💢 No 25. Was case referred to medical examiner?
1 ☐ Yes 2【▼ No 26. Place of Death (Check only one) Be Hospital ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate; 1 XNatural injury Accident 5 Pending Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) 24 hours Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2. 29b. Signature and title of certifig 29c, License number 29d. Date signed (Month, Day, Year) November 3, 2011 D67691 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

State

Registrar

Mark Goldstein, M.D.

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Registrar's Signat

park

501 W. 7th Street #1A Frederick, MD 21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35229 State of Maryland / Department of Health and Mental Hygiene 2 0 State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Month MADELINE BAUMANN LAMBERT 11:00 A M November 2011 Medical 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Love Assisted Living Laurel Prince George's Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 577-42-6270 85 1 M 2 X F Dec 29, 1925 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Xyes 2 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Tulip Drive U.S.A. 20877 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?
1 ☐ Yes 2XXNo þ 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: If Yes Give Specify: White 3 XXVidowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Automobile 4 years Accountant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Odilo Baumann Marie Kaefer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 116 Tulip Drive Gaithersburg, Maryland Hope Susan Lambert 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial ZXX Cremation 3 ☐ Removal from State cemetery, crematory or other place) W. Arundel Crematory 11/4/2011 Odenton, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. / M00770 Laurel 313 Talbott Avenue Maryland 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Vascular Dementia years disease or condition resulting in death) Due to (or as a consequence of) To Be Completed by Physician/Medical Examine

Medical Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and attending physician Division of Vital Records, P.O. Box 68760 be detached signed by page 2 After this funeral n 24 hours ofter death. e Funeral Director Aft bletely filled in by the ful

show

items 23a or 28a-f sho ner must be notified at

"natural", or iten edical Examiner r

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permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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Examiner	Sequentially list conditions, in any, issuing to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to for as a conseq	tier oe ci):				
	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):	.		***	
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregni 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🔲 Ectopi			23d. Date of de Month	alivery Day Year
	Part II. Other significant conditions co	ntributing to death but not re	sulting in the underlying	g cause given in Part I.			o the cause of death?
Completed					24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
Be (25. Was case referred to medical			26. Place of Death (Che	eck only one)		
To B	examiner? 1 Yes 2xxvo	Hospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	ce 6XXOther (Spe	Assisted
	27. Manner of Death 1 → Autural 5 □ Pending 2 □ Accident □ Investigation		28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how	injury occurred	Living
Medical Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif	ome, farm, street, factory)	ory, office	28f. Location (Stree City or Town, S	et and Number or Ri State)	ural Route Number,
l edica	(Check 2 Medical Examin	ician: To the best of my know ner: On the basis of examination the Practationer: To the best of	on and/or investigation,	in my opinion, death occurred	at the time, date and	place, and due to the	e cause(s) and manner stated
2	29b. Signature and title of confier	/ //		9c. License number		d. Date signed (Mon	

Kensington, Maryland

DHMH 17 Rev 06-2011

State Registrar

iDV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Barry N. Rosenbaum, M.D. 3720 Farragut Avenue

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Lundberg Mary Yvonne Month Physician/ 1145 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STAGNES BALTIMORE CIT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9 Birtholace (State or Foreign 7. Age (In vrs. last birthday) Funeral Country Missouri 1 🗆 M 2 🔀 F 10//9/8//1/9/37 74 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10h County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City Howard 1 🗓 📞 €es 2 🗆 No 10f. Zip Code 21043 10g. Citizen of What Country? Funeral 8700 Ridge Road, Apt. 206 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: White Specify: "natural", 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Interior decorator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Reddick Glennon Joseph 19a. Informant's Name/Relationship (Type, Print)
Vickie Hallenbeck/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8426 Governors Run, Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Chesapeake Crematory 11/4/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 SETUNERAL Service Licensee Dorota Marshall (23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician/ ENTERO COCCUS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): and I-transit that initiated events Due to (or as a consequence of) resulting in death) Last ied by the attending physician a detached for use as the burial-Physician/Medical $101000 \text{ M} \cdot 1000 \text{ M} \cdot 1000 \text{ M} \cdot 1000 \text{ M} \cdot 1000 \text{ M} \cdot 1000 \text{ M} \cdot 10000 \text{ M} \cdot 10000 \text{ M} \cdot 10000 \text{ M} \cdot 10000 \text{ M} \cdot 10000 \text{ M}$ IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by URINARY TRACT INFECTION, ATRIAL 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? FIBRILLATION, OVARIAN CANCER 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) To Be 25. Was case referred to medical examiner? Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2011 DC1825 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVENUE BALTIMOSS REYNALDO LEE-CLACERITIMD State

DHMH 17 Rev 7/2009

Registrar

State Registrar 31. Date filed (Month, Day, Year)

NOV 0 4 2011



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35232 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November of 2019 2:20 P M Jane Fulton Mangione Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice Columbia Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 X F Months Days Hours Feb 25, Year) 922 **Director** Maryland 89 213-18-8446 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Columbia Howard 10e. Street and Number ò 10f. Zip Code "natural", or items 23a or edical Examiner must be 10g, Citizen of What Country? Funeral 10706 Shady Summer Drive 21044 USA 1 and 2 should be filed within 72 hours after death if Heath and Mental Hygiene. It marked other than "natural", or items item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) A and Mental river Homemaker 12 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jesse James Fulton Cora Edith Rudy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2665 Legends Way Ellicott City, MD 21042 Connie M. Saunders/daughter Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott . Page 1 Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 11/3/11 Woodbine, MD Signatule of Funeral Service Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final COMPLICATIONS Ph_sician/ Onset and Death disease or condition MONTHS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of, attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes 2 ₽ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed After this certificate 2 🗆 No 1 ☐ Yes 2 🗶 No 1 Yes BB 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 X No Other: 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 💆 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending injury Il Director: Af Investigation 6 Could not be 1 Yes 2 No Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi D64395 NOVEMBER 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DOBERMAN, MO DANIEUE 31. Date filed (Month, Day, Year) 32. Registrar's Sigrature State NOV 04

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Moone 26 11 CYPA November ااط Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mespita Balti more If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Country) **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location at Director notified 1 **X**es 2 □ No 10g. Citizen of What Country? ò and Number Examiner must be Funeral with 23a "natural", or items permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 D Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ROPES state Be Father's Name (First, Middle, Last) 18 ပ IOR 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 1212 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between set and Death erebral Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Minutes Examiner Secure tially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) for use as the burial-transit the attending physician and that initiated events resulting in death) Last Due to (or as consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown q Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performe death? 1 ☐ Yes 2 Mo 1 Yes 2 No 26. Place of Death (Check only one) Be Hospital: ည 1 ☐ Inpatient 2 🗭 ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after deatl To the Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar

State

31. Date filed *(Month, Day,*

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South KALDOVER

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Street

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Lee.	permit. Page 1 and 2 should be filed within 72 hour permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturally injury or other traumatic event, the Medical once.		20a. Method of Disposition 1 ■ Burial 2 □ Cremation	201	b. Place of Disp cemetery, cre	osition (Name of matory or other pla	ce)	Date	20c. Location	- City or Town, Stat	
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Division of Vital Records	al or Attending Phys s after death. Il Director: After this ed in by the funeral di	Certi	3 Suicide 6 Could at 4 Homicide determine		t home, farm, st ecify)	reet, factory, office		28f. Location (City or To		ber or Rural Route I	lumber,
	To the Hospital or Attending Physician: The law requires that the death certificate twithin 24 hours after death. To the Funeral Director. Attending physician: The law requires that the death certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the law representations.	Medical Certificate:	(Check 2 Medical E	Physician: To the best of my kn xaminer: On the basis of examina Nurse Practitioner: To the best	ation and/or inve	stigation, in my opini	ion, death occurred	at the time, date	and place, and d	ue to the cause(s) ar	id manner stated.
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			For State Registrar	State of Ma	aryland	-	irtment of F tificate of L		and M	lental Hy	giene Reg. No.	20	1	35235
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24	Examin		4a. Facility Name (if not institution, give	street and number)			4b. City, Town, or	Location	of Death		4c.	County o	of Death	
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		1	-	atory or other place idel Cren		Nov.	2,	Ođer	nton	- MD	
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760	phys phys the	edical		d									\pm	
89	sertific oding Ise as	<u>Z</u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnan	cy						23d. Date	of deliv	en/
P.O. Box 68	atter	Physician/M	in the past 12 months?	1 ☐ Live Birth 2 4 ☐ Pregnant at			Ectopic pregnance Other (specify)	У				Mon		Day Year
B	the de	hys	9 Unknown	9 Unknown										
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S,	quires en sig auld b									1 🗆	Yes 2 ₺	☑ No 〔	3 🗌 Pro	bably 4 🗌 Unknown
Ö	w rec is bee 2 sho	Completed								24a. Was		24b. W	ere auto	psy findings available mpletion of cause of
3e	sician: The law is certificate has bilirector, page 2 s	mo(ormed? 2 🔀 No	de	eath?	2 No
e	ian: ertifica ctor,	Be (25. Was case referred to medical examiner?	ű.			26. PI	ace of Dea	th <i>(Check</i>					
₹	hysic his ce il dire	힏	1 ☐ Yes 2xxNo	Hospital: 1 ☐ Inpatie	nt 2 🗆 E	R/Outpatien	t 3 DOA Othe	er: 4 🗆 N	ursing Hor	ne 🗚 🛣 Resi	dence 6	Other	(Specify)
of	ng P	ate:	27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of injury (Month, Day,		28b. Time of injury	28c. Injury work	/ at ?	2	8d. Describe	now injury	occurred	d	
jo	tend death tor: A	ific	2 Accident Investigation 3 Suicide 6 Could not be	e				Yes 2 L						
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours affer death. To the Funeral Director: Affer this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate:	4 Homicide determined	28e. Place of Injur building, etc.	y - At non (Specify)	ne, farm, stre	et, factory, office		2	28f. Location (City or To		Number	or Rura	Route Number,
Δ	spital ours ieral filled	edical	29a. Certifier 12 Certifying Phy	sician: To the best of r	nv knowle	dge death o	courred at the time	date and	I place, an	d due to the c	ause(s) an	nd manne	er as stat	ed.
	e Hos 124 h e Fun letely	Medi	(Check 2 L Medical Exam		amination	and/or investi	gation, in my opinio	n, death o	ccurred at	the time, date	and place,	and due	to the ca	use(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier		2001 01 111	y kilowicage,	29c. License		ate and prac	je, and dde te				Day, Year)
			1 Kake	1/02	3	MD	D254	22			Novem	nber	1.	2011
	15.1		30. Name and address of person who				rint)							
	15V		Robert Maggin, MI				e., Laur	el, N	1D 20	707				
	Stat	_	31. Date filed (Month, Day, Year) NOV 0 4 2011	32. Registrar	's Signatu	ire Kal								
	Registra	1	MA O T TOLL	1	17									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ LINDA LEE MALOZI OCTOBER 30, 2011 11:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Jan. 24, Year 1948 Country) Maryland 1 □ M 2**X** F Days Hours Min 63 Director 214-50-7399 Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2XXNo MD Harford Abingdon 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral IIS 21009 805 Tiffany Trail Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes XX No Specify: White Specify: "natural" Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Western Electric 12 Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Elizabeth Meisling Page 1 and 2 should be Raymond Baggerly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 Tiffany Trail, Abingdon, MD 21009 Richard F. Malozi (spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/3/2011 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Interval Between Onsit and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on requires that the death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 I Ilnknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 **N**o 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Watural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper C Kurtom hisapeake

√ DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 26,2011 8:18A. Frank Harold Miller Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Balto. 5123 Henry Avenue Nottingham 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**□M 2 □ F Hours Maryland **Director** 80 217-26-7052 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Nottingham Md. Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a or the Medical Examiner must be Funeral IISA 5123 Henry Avenue 21236 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 XYes 2 No Black, White, etc 1 Never Married 2 X Married þ Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify. 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Esskay 12th Truck_Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alma E. Dietrich Frank H. Miller permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5123 Henry Avenue Nottingham Md,. 21236 Rita M. Miller Spouse Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-31-2011 Baltimore, Md. Most Holy Redeemer 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licenses takacie Nottingham, Md. 21236 9705 Belair Road 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due t is as a consequence of) Examiner Sequentially list conditions, if any hading to immediate cause. Enter Underlying Due to for as a consequence of Examir Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death the i 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ FAILUTE 2 ■No 3 □ Probably 4 □ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director; After this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of filled in by the funeral 28d Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗀 only one) 29b. Signature and title of certifier 111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOAD State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35238 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octobor 20% 00N . Medical 4a. Facility Name (if not institution, give street and number County of Death **Examiner** Georges Khode FINCE 5 land . Sex 1 【¥ M 2 ☐ F If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number 7. Age (In yrs. last birthday, If Under 1 Year Funeral 88 Months Month Day, Hours Min 220-72-0932 orea Director Usual Residence of Deceden 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Numbe 9014 U.S.A AVe 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💆 No Specify: Specify: ASIAN 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) automotive echanic Be 18. Mother's Name (First, Middle, Maiden Syrname) 17. Father's Name (First, Middle, Last) မှ HWO DUN G DUNCY MOON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Informant's Name/Relationship (Type, Harbin Field EllicoTT daughter STY IMD 20a. Method of Disposition 20b. Place of Disposition (Name of Date Norbeck Mem Cemetery 10-31-2011 1 Burial 2 Cremation 3 Removal from State Ol Ney, Maryland 4 Donation 5 Other (Specify) FUNERAL HOULE 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 10220 Guifford Road 20794 essup, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between SMALL (ELL LUNG (ANC Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or ilnjury that initiated sease or inspections) Examine Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical b Hospital or Attending Physician; The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Cher significant conditions contributing to death but not resulting in the underlying cause given in Part Ly 23e. Did tobacco use contribute to the cause of death?

23e. Did tobacco use contribute to the cause of death?

25e. 2 | No 3 | Probably 4 | Unknown | Unknow Be Completed by 3 Probably 4 Unknown PHAGIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate has funeral director, page 2: 1 Yes 2 No To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 🗌 Yes 2 No 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the only one) 29b. Signature a Suite 306 oleted cause of death (Item 23a) (Type, Print) ANNapolis babila Kond anham, MD

DHMH 17 Rev 7/2009

State

Registrar

4 2011

			For State	State	of Maryla				d Mental H	ygiene 2	011	35239
			Registrar 1. Decedent's Name (First, Middle	e last)		Cer	tificate of	Death	2. Date of D	Reg. No.		3. Time of Death
F	Physicia Medic		Glenna Mae Mi							er 30,	20 Î Î	3:45 PM M
	Examin		4a. Facility Name (if not institution	, 0	,			or Location of D)eath		nty of Death	
			Anne Arunde1 5. Social Security Number	Medical 6. Sex	Center 7. Age (In yrs.	het hirthday)	Annapo		Hrs. 8. Date of B		Arun	nplace (State or Foreign
	uneral irector		152-28-1402	1 □ M 2 🔀 F			Months Days		vin. DEc 2.	I, Year) 937		ew Jersey
р	at at	,	Usual Residence of Decedent 10a. State 10b. County		100.0	City, Town or Loc	eation					10d. Inside City Limits
larylar	a-fsh ified	ecto	,	Arundel	100.0		no1d					1 Yes 2 No
the M	a or 28 be not	I Dir	10e. Street and Number	, ill dildel			10f. Zip Code			10g. Citizen	of What Cou	untry?
th with	ms 23	Funeral Director	305 College Pa					21012			SA	
U36 rs after deal	Deportment or result and wentain tryptene. Importants if then Z' is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☒ Divorced	ried Armed F		ŀ	Vas Decedent of f Yes, specify Cub ☐ Yes 2 X N	oan, Mexican, Pi	? (Specify Yes or No uerto Rican, etc.)	В	Race - Ameri Black, White cify: Wh	
1215-0036 hin 72 hours after	ne. than "natu se Medical	Completed			d) (1-4 or 5+)	(Give I life, De	lent's Usual Occu kind of work done O NOT use retired	during most of d)		16b. Kind of		
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Saltimore, permit. Page 1 and	ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 🏹 Donation 5 ☐ Other (\$			Place of Dispo cemetery, cren	sition (Name of natory or other pla	ace)	Date	20c. Locatio	n - City or 1	Town, State
balt permit.	Import any inj once,		21. Signatur, of Funeral Service	censee A	recto	1	Name and Addr ate Anal	-	ard 655 W	. Balti	more	Street
			23a. Part 1. Enter the disease, or shock, or heart failure. List of Immediate Cause (Final	only one cause on	each line.	ath. Do not ente	er the mode of dy	ing, such as care	diac or respiratory			Approximate Interval Between Onset and Death
	sician/ ledical		disease or condition resulting in death)	a. Due to	o (or as a) nse	guence of):	Iteach	Fai	lung		\rightarrow	> ly
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execut	physician and the burial-transit	Еха	that initiated events resulting in death) Last	c. Due to	o (or as a conse	quence of):						
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dS, r.O	en signed k ruld be dett	ted by P	Part II. Other significant condition	ons contributing to	death but not re	esulting in the u	nderlying cause g	given in Part I.				the cause of death?
Records, The law requires	cate has be	Comple							24a. Wa aut per 1 🗆 Yes	opsy formed?	prior to c death?	opsy findings available completion of cause of
VILCIII /sician:	certific	Be c	25. Was case referred to medical examiner? 1 ☐ Yes 2 💆 No	Hospital:	D		Ot	Place of Death (
o o	ter this neral di	te: To	27. Manner of Death 1	28a. Dat	Inpatient 2 [e of injury enth, Day, Year)	28b. Time of injury	t 3 LJ DOA 28c. Inju	4 ∐ Nursir ury at	ng Home 5 Res 28d. Describe	sidence 6 🗆 C how injury occ		fy)
VISION OF A Attending Pitter death.	tor: Af the fu	Certificate:	2 Accident Investignment of Could	gation			M 1	Yes 2 □ No				
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he Hospit in 24 hour	he Funera	Medical	(Check 2 Medical E	Physician: To the Examiner: On the b Nurse Practione	asis of examinati	ion and/or invest	igation, in my opir	nion, death occur	rred at the time, date	and place, and	due to the c	ause(s) and manner stated.
To t	To con		29b. Signature and title of certifier	D &	7			se number	//	29d. Date sig	1 1	
			30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type, P	rint)	2 40	7	20/	10/1	MD 21401
			Robert 1	T Pe	terso	1 n	47	AAN	1C	Luncy	elec 1	MD 21401
F	Stat Registra		31. Date filed (Month, Day, Year)	1 1/39	Registrar's Sign	ture far						

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

of Vital

Division

32. Registrar's

3524

1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10/30/2011 **Physician** Dorothy Mazurek 8:20am^M /Medical 4a. Facility Name (If not institution, give street and number)
Seasons Hospice / Future Care Canton 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore N/A ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1/6/22 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 2121741448987 89 1 □ M 200 F Director MD Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location show 10a. State 10b. County item 27 le marked other then "neturel", or Items 23e or 28e-f shov other treumetic event, the Madical Examinar nation at MD 1 Yes 2 □ No N/A Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21201 LISA 1 W. Conway Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes **XXX**No ff Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 2 should be filed within 72 hours after a nand Mental Hygiene. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXIo Specify: White Specify: þ ₩Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Colfege (1-4or 5+) Homemaker Own Home 8 0 17. Father's Name (First, Middle, Last)
John Tyson 18. Mother's Name (First, Middle, Maiden Surname) Be Gusta Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Importent: If item 27 le n eny injury or other treun QDGE. Genevieve Byczynski / Daughter 1 W. Conway Street, Baltimore MD 21201 20b. Place of Disposition (Name of cometery, crematory or other place)
Cedar Hill Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 tment of I 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/3/2011 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral Service Licensee Victor P. Doda Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Mycholyo Plasho syndrome Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): ed by the attending physicien detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 TV No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. mo mus 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 21110 2 No 1 Tes Hospitel or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 █ No P 27. Manny of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

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completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20011150 10/31/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MELITO M. TORNES, MD 441 SOUTH FULLWOOD AVE, BALTO, MD 21224 31. Date filed (Month: Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Florence Ostrofsky November 2011 4:00 P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Edenwald Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 1, 1921 Birthplace (State or Foreign Country)

Canada 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F Director 091-12-1857 Usual Residence of Decedent 10a. State 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified MD 1 Yes 2 No Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 Southerly Road 21286 USA "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify Specify: White 3 ₩ Widowed 4 □ Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. s marked other than " umatic event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Menov Anna Rotkin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other trau once. Charles Ostrofsky/son 4515 Willard Ave. #1802 Chevy Chase, MD 20815 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Place of Disposition (Name or Commetery, crematory or other place)

Final Journey Crematory 11/04/11 1 Burial 2X Cremation 3 Removal from State Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 21. Signature of Funeral Service License Beverly L. Heckrotte, P.A. Clarksville 23a. Part 1. Enter the or ease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a cons use as the burlal-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Box 68760 that the death certificate IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 month Live Birth 2 Fetal death 3 Ectopic pregnancy detached for Day Month Year 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be the Hospital or Attending Physician: The law requires Records, 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate 1 🗌 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) . 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manu of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of 29b. certifie 29d. Date signe (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Joil and October 1513 PM alvin Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death General Howard County Hospital Columbia Howar 5. Social Security Number If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 1 M 2 □ F Days (Month, Day Year) Mar 21, 1946 216-48-2163 65 MD Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Woodstock MD **Baltimore** 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1509 Grooms Ln. 21163 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?/ 1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 → Widowed 4 □ Divorced Specify Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retire Elementary/Seconday (0-12) College (1-4 or 5+) **Delivery Man Propane Delivery** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rosalie LaRue Sullivan Charles S. Oland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Brantley daughter 1511 Grooms Lane Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State emetery, crematory or other place)
Poplar Springs Cemetery Nov 02, 2011 Poplar Springs, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 293 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Atherosclerotic Physician/ Coronary unknown disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at Id be detached for Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has ral director, page 2 autopsy performed? 2 No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗍 within 2 only one) 29b. Signature 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Cedar Lane, Columbia, MO 210 84

State Registrar

DHMH 17 Rev 7/2009

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Henggeler, MD

32. Registrar's Signature

Michelle 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 35244 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Payne, Jr. Howard 7:50 P M <u>October</u> 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Sandy Spring Montgomery Brooke Grove Nursing & Rehab. Center 9. Birthplace (State or Foreign Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours July 18, 1919 1 XM 2 - F Director Maryland 056-18-5410 Usual Residence of Decedent ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20906 United States 2129 Blue Knob Terrace hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. ed Forces? Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 XYes
If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: 3 ☑ Widowed 4 ☐ Divorced Black Completed Year or Dates. 1944-45 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other th Attorney Law Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Coleman Payne, Sr. Marie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 20906 Anne P. Fugett / Daughter 2129 Blue Knob Terr., Silver Spring, MD permit. Page 1 and 2 Department of Healtl Important: If item 2 any injury or other t injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 11/02/2011 Beltsville, MD 4 Donation 5 Other (Specify) Chesapeake Crematory M0038Z Rapp and Gremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician PNEUMONIA DAYS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): ding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ATRIAL FIBRILLATION, DEMENTIA, TYPE II DIABETES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2X N certificate 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: XX Nursing Home 5 - Residence 6 - Other (Specify) 1 🗌 Yes 2 💢 No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death funeral 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 5 \square Pending 1 🔀 Natural e Funeral Director: A sleted filled in by the fu Accident 1 Yes 2 No Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c License number 29d. Date signed (Month, Day, Year) OCTOBER 31, 2011 D43202 MY

State Registrar 3305 N. LEISURE WORLD BLVD., SILVER SPRING, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHARLENE OZANNE-BLANKFORD, M.D.

NOV 0 4

31. Date filed (Month, Day, Year)

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	Dhyoinia	- /	1. Decedent's Name (First, Middle, Last)		tinoato or E	- Catiri	2. Date of Dear		3. Time of Death
	Physicia Medic	ai	Frances Carol Palermo 4a. Facility Name (if not institution, give street and number)			1		30,2011 Year	10:30P M
	Examin	er	2410 Cedar Mill Road		4b. City, Town, or Par	kville	tn	4c. County of Dea Balto	
	Funeral Director		212-60-4637 1 M 2 XF	n yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		9. Bir 2,1952 Ma	thplace (State or Foreign untry) ryland
	nd show at	'n	Usual Residence of Decedent 10a. State 10b. County 16	Dc. City, Town or Loc	ation				10d. Inside City Limits
	Maryla 28a-f s otified	Director	Md. Balto.	Parkv	ville				1 🗆 Yes 2 🔀 No
	ith the	ral D	10e. Street and Number		10f. Zip Code	,		10g. Citizen of What Co	ountry?
	eath w	Funeral	2410 Cedar Mill Road 11. Marital Status 12. Was Decedent Ever		2123 Vas Decedent of Hi	spanic Origin? (5	Specify Yes or No-	USA 14. Race - Ame	erican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by F	1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates.		Yes, specify Cuba		rto Rican, etc.)	Black, Whit Specify:	e, etc. White
15-(72 hou n "nati ledica	nplet	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation of work done of		orking	16b. Kind of Business	Industry
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land	d be filed Jental Hy Irked oth	To Be	17. Father's Name (First, Middle, Last) Guido Palermo				ame <i>(First, Middle, M</i> ia M. Kro	·	
Man	d 2 shoul alth and I 1 27 is ma er trauma	·	19a. Informant's Name/Relationship (Type, Print) Evelyn DelBrocco Siste		g Address (Street a Eden Far			City or Town, State, Zi ster, Md.	
Baltimore, Maryland	Page 1 an Ient of He nt: If iten ry or othe		1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispos cemetery, crem Dulaney V	natory or other plac		Date 4-2011	20c. Location - City or	
Balti	permit. F Departm Importa any inju	9	21. Signature of Funeral Service Licensee		. Name and Addres	s of Facility S elair R	chimunek oad Nott	Funeral Ho ingham, Md	me.Inc. . 21236
ı			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.					est,	Approximate Interval Between
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	cate be executed physician and the burial-transit	al Exa	that initiated events resulting in death) Last C. Due to (or as a co	nsequence of):				-	
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P.O. Box 687	eath certif attending I for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 4 Pregnant at tin gold linknys.	Fetal death 3	Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
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ds, P.	r requires that the der been signed by the s should be detached	ed by	Part II. Other significant conditions contributing to death but r	ot resulting in the ur	nderlying cause giv	en in Part I.		bacco use contribute to es 2 🗆 No 3 🗆 F	o the cause of death? Probably 4 Unknown
Division of Vital Records,	hysician: The law red his certificate has bed il director, page 2 sho	Completed by					24a. Was a autops	sy prior to med? death?	utopsy findings available completion of cause of
E E	sian: T ertificat ctor, p	Be C	25. Was case referred to medical examiner?		1	ace of Death (Ch	1 \(\sum \) Yes eck only one)	2 No I Te	s 21_nvo
Ž	Physic this c	မ	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 27. Manner of Death 28a. Date of injury	2 ER/Outpatient	t 3 DOA Othe	4 L Nursing		ence 6 Other (Spec	cify)
ouo	ending sath. r: After	ficate	1 Natural 5 □ Pending (Month, Ďay, Ye 2 □ Accident _ Investigation		work	? Yes 2 No	Zud. Describe no	ow injury occurred	
Divisi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 64 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury building, etc. (S		et, factory, office		28f. Location (St City or Town	reet and Number or Ru n, State)	ral Route Number,
	Hospi 24 hou Funer leted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examonly one) 3 Certifying Nurse Practioner: To the best of my 2 Medical Examiner: To the best of my 2 Certifying Nurse Practioner: To the best of my 2 Certifying Nurse Practioner: To the best of my 2 Certifying Nurse Practioner: To the best of my 2 Certifying Nurse Practioner: To the best of my 2 Certifying Physician: To the best of my 2	nination and/or investi	igation, in my opinic	n, death occurred	d at the time, date an	d place, and due to the	cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier		29c. License	number	2	29d. Date signed (Mont	h, Day, Year)
			S 1 m		950	1232		11/2/1	1
			30. Name and address of person who completed cause of death	(Item 23a) (Type, Pr	Shook	RA	5/312	11/2/1 3/xeus M	52115
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's	Signature					

			For State	State of Maryla				Mental Hy	giene	- 1 t	352	1.6
			Registrar	£)	Cer	tificate of E	<i>Death</i>	1	Reg. No.			
	Physicia	n/	1. Decedent's Name (First, Middle, Las	_				2. Date of De Month	Day	Year	3. Time of I	
	Medic		Albert 4a. Facility Name (if not institution, give	Parker		41. O'l. To	Landley of Dood	10	28	2011	1:59	PM
	Examin	er			ا معلمه	4b. City, Town, or		1	4c. Coun	ty of Death		
	Funeral	2	Social Security Number 6. \$6		last birthday)	Baltimon If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or	Foreign
	Director		219-40-3267	X M 2 □ F 65	Yrs.	Months Days	Hours Min.	June, D	y, Year 946	Cour	notes d	unk
	d ow	_	Usual Residence of Decedent 10a. State 10b. County	T ₄₀ - 0	* T	-11					40.1.1.1.1.015	. 1.1. 21
	ırylan a-f sh ied a	cto		10c. C	ity, Town or Loc						10d. Inside City	
	ne Ma ne 188	Dire	MD 10e. Street and Number		Baltin	10f. Zip Code			10g. Citizen o	f What Cou		2 110
	with the 23a cast be	eral	1217 W. Fayette	Street			1217		US.		ind y :	
	eath v	Funeral Director	11. Marital Status unk	12. Was Decedent Ever in U	.S. 13. W	las Decedent of Hi Yes, specify Cubar	spanic Origin? (Sp	pecify Yes or No-	14. Ra	ace - Ameri	can Indian,	$\overline{}$
õ	fter d , or i	by	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	unk	Yes, specify Cubai		o Rican, etc.)		ack, White,		
9500-61212	ours a tural' al Ex	Completed	3 Widowed 4 Divorced	Year or Dates.					Speci	fy: b1	ack	unīz
7	72 hc n "na ledic	nple	15. Decedent's Ed (Specify only highest gra	de completed)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired)		unk ^{king}	16b. Kind of	Business Ir	ndustry	unk
7.	vithin iene.	Cor	Elementary/Seconday (0-12) unk u	College (1-4 or 5+)	ille. DC	TWOT use retired)						
<u> </u>	filed within 72 hours after death with the Maryland al Hygene. dother than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		<u> </u>	unk	18. Mother's Nar	ne (First, Middle,	Maiden Surna	me)		unk
/lar	d be 1 Menta arked atic e	J D										
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mertell Hygiene. At the fleath and Mertell Hygiene. If flem 27 is anaked other than "natural", or items 23a or 28a-f show if if ether Iraumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Ty) University of MD	. ,	19b. Maifin	g Address (Street a	nd Number or Ru Street	al Route Number, City or Town, State, Zip Code) Baltimore, MD 21201				
di O	and 2 Health em 2: ther t		20a. Method of Disposition				· ·					
٥	age 1 int of t: If it		1 Burial 2 Cremation 3 D	Removal from State	Place of Dispos cemetery, crem	atory or other place	e)	Date	20c. Location	1 - City or I	own, State	
baltimor	permit. Page 1 a Department of I Important: If ite any injury or of		4 ☐ Donation 5 ☐ Other (Specify 21. Sign 1 e of Funeral ervice License	ne -//	22.	Name and Addres	s of Facility	1 (55 1	. D.1.		Ctmoot	- 7
ŏ	Der Imp		Juni 10	Directo		Name and Address tate Anat altimore,		ra 655 W 201	. Baiti	Lmore	Stieet	
			23a. Part 1. Enter the disease, or comp slock, or heart failure. List only or	lications that caused the dea e cause on each line.	th. Do not enter	r the mode of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Betw	
~~ P	Physician/		Immediate Cause (Final disease or condition	. Anoxic e	ncenh	alopath	V				Onset and De	
	Medical Examiner		resulting in death)	Due to (or as a consec		1	1					
		er	Sequentially list conditions,	b. —								
	ed	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consec	juence oij.							
	xecut n and al-trar	Exa	that initiated events resulting in death) Last	c. Due to (or as a consec	uence of):	-						
2	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	dical Examiner	L	d								
0/00	ifficate ng phy as the		IF FEMALE:									
Ď	h cert tendir ir use	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn 1 ☐ Live Birth 2 ☐ Fet		Ectopic pregnancy	y			ate of deliv		
ם כֹּ	e deat the at hed fo	Physician/Me	1 Yes 2 No	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 □	Other (specify)			"	1onth	Day Ye	ear
5	at the		Part II. Other significant conditions co	ntributing to death but not re	sulting in the ur	nderlying cause give	en in Part I.	23e. Did t	obacco use cor	ntribute to t	he cause of de	ath?
ກໍ	signe signe d be o	d b	Cardiae Arrest						Yes 2 □ No			
ecords,	requiper peen shoul	lete						24a, Was	an 24b	. Were auto	opsy findings av	/ailable
၌ ည	e has ge 2	Completed						auto perfo	psy ormed?	prior to co death?	ompletion of ca	use of
= ;	an: If tificat tor, pa		25. Was case referred to medical			26. Pla	ace of Death (Che		2 X No	1 🗌 Yes	2 N No	
. II	iysici is cer direci	10 B	examiner? 1 ☐ Yes 2 🔀 No	lospital: 1 🛣 Inpatient 2 🗆	BR/Outpatient	Othe	r·	lome 5 🗆 Resi	dence 6 \square Ot	her (Specif	iv)	
5	ng Ph Iter th neral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at	28d. Describe I				
5	tendin leath. or: Ai the fu	itica I	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No					
LIVISION	or At after of Direct in by	Certificate:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specif		et, factory, office		28f. Location (S City or Tov	Street and Num vn, State)	ber or Rura	d Route Numbe	ər,
: כ	spital lours a neral l	edical	29a. Certifier 1 X Certifying Phys	cian: To the best of my know	/ledge. death o	ccured at the time.	date and place, a	nd due to the ca	use(s) and mar	iner as stati	ed.	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Med	(Check 2 Medical Examin	er: On the basis of examination of the best of m	on and/or investi	gation, in my opinio	n, death occurred	at the time, date a	and place, and d	lue to the ca	ause(s) and man	ner stated.
,	Noth Con		29b. Signature and title of certifier			29c. License			29d. Date sign	ed (Month,	Day, Year)	
			Kyn Syla M	D			74914		10/28	1201	1	
			30. Name and address of person who co	empleted cause of death (Iter	n 23a) (Type, Pr	int)	210	M I	1 212	m)		
	Stat	e_	Kyan Spange, MD 31. Date filed (Month, Day, Year)	22 South (ature ARK	Sticet	UKITMORE	, marylar	v LIL	<u> </u>		
	Registra	٠,	NOV 0 4 2011	Server F.	1							

11-07933 LINK LINK

JNK UNK		S - For State Registrar	tate of Maryla		artment of rtificate of			Menta	al Hy		Reg. No.	20	Bicomost	3524
Physician Medical Examine	1/	1. Decedent's Name (First, Midd	inkney	 -						2. Date of De Month October :		Year		3. Time of Death 2054 hrs
		4a. Facility Name (if not instituti University Hospital	on, give street and nu	ımber)		4b. City, To Baltimo		ocation of		0010001		County of	Death	
Funeral Director		5. Social Security Number Unk	6. Sex	7. Age (In yrs. I		Months	1 Year Days	If Under Hours	24Hrs. Min,	8. Date of B 7/31			9. Birth Foreign Cour	
nd show any ICC.		Usual Residence of Decedent 10a. State 10b. County Unk Unk •		10c. City Unk	, Town or Locat	ion								10d. Inside City Limits 1 Yes 2 No
the Maryland a or 28a-f show iffice at once.		10e. Street and Number Unk.		. .		10f. Zip 0 Unk .					10g. Citize USA	en of Wha	t Count	ry?
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	by Funeral		farried Armed Find Arm	2K No	If Y	Yes 2	Cuban, I	Mexican, F	Puerto R		s	White, Specify:	etc. Bl	an Indian, Black,
1036 Aithin 72 hours ene. Er than "natur Medical Exam	mpleted	15. Decedent's Education (Spe Elementary/Secondary (0-12)	College (*		16a. Deceder during m Unk .	nt's Usual 0 lost of worki	ng life. [OO NOT u	se retire	d)	τ	nd of Bus	iness/In	dustry
21215-0036 Suld be filed within 7 Mental Hygiene. I marked other than ic event, the Medica	8	17. Father's Name (First, Middle Samuel Pinkne	y, Jr.		40h Mallia	a Address		Yola	ında	First, Middle, K. T Iral Route No	homps	son	State	Zin Codo)
MD 2 d 2 should lith and M m 27 is m numatic		19a. Informant's Name/Relation Samuel Pinkne	ey, Jr. /Fa		96 Ca	arniva	al Di	rive,	Tai	ney To	wn MI	217	87	
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and I Important: If I tem 27 is in injury or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other 5	Specify:	rom State	Place of Dispos crematory or ot Ardent (her place) C rema t	ory		11/2	Date 2/2011	Har	over	Ma	ryland
Balt permit Depart Impor injury	4	Signature of Funeral Service 23a. Part I. Enter the disease, o		>	1	ame and Anarles	ddress of L	Stevert Av	rens renu	Funer e, Bal	al Ho	ome, ce MI	Inc 21	230 Approximate Interval
Physician Examiner		23a. Part I. Enter the disease, o failure. List only one causi Immediate Cause (Final diseas or condition resulting in death)	e on each line. e a. <mark>Gunshot W</mark>		the Neck ar		dyllig, si	ucii as cai	ulac of 1	respiratory a	nest, snoc	r, oi neai		Between Onset and Death
	<u>_</u>	Sequentially list conditions, if any, leading to immediate		a consequence o	of):								-	
uted Id ransit	Exal	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence o	of):									
50, te be executed ysician and burial - transit	edica	UNPENDED	AMENDED							_	224	Data of a	lalivan	
certifica nding ph		IF FEMALE: (3b. Was decedent pregnant in past 12 months?) 1 Yes 2 No 9 Ur	the 1 Live t	nant at time of de	2 Fe	etal death ther (Specif	3 [jy)	Ectopic	pregnan	су		Date of o	Da	ay Year
res that the d signed by the lbe detached	2	Part ii. Other significant cond	tions contributing to	o death but not r	resulting in the t	underlying o	ause giv	en in Parl	i i.			No 3	Proba	ne cause of death?
Division of Vital Records, P.O. Box Within 24 hours after death within 24 hours after death. To the Buncard Director. After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for united to the complete of the complete	Completed									peri 1 ✓ Yes	s an opsy formed? 2 No	pr de		opsy findings available ompletion of cause of
Vital I hysician: his certifi I director,	o Re	25. Was case referred to medic examiner? 1 ✓ Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatient		10	of Death (Cother		Home 5	Residen	ice 6	Other:	
Sion of Attending Ph		27. Manner of Death 1 Natural 5 Per	28a. Date (Month Oct 21, estigation	of Injury 1 Day Year) 2011	28b. Time of 2005 hrs	Injury 28		at Work?	lo	28d. Describe Subject sh		y occurre	d	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: /	Certification:	3 Suicide 6 Cou	28e. Plea ermined (Specify)	se of Injury - At h Street					2	or Town, 800 block	State) Noodbro	ok Ave,	Baltimo	
To the Hos within 24 h to the Fur completely	Medical		Physician: To the be- aminer: On the basis and manners	of examination a										
To vit	¥ ·	29b. Signature and title of certif		Stated.			License O.C.M					ate signe ber 22,		th, Day, Year)
OCME		30. Name and address of person Mary O. Ripple MD.	Deputy Chief	Medical Exa	miner 900) W. Balt	more	Street,	Baltim	ore, MD 2	21223			
Star Registra		31. Date filed (Month Day, Xear	2011 32. 7	gistrār's Signat	L. La	wes								

		Please	Type or Print in Black I			
		For	State of Maryland / Dep		Mental Hygi	
		State Registrar		rtificate of Death		g. No.2011 35248
Physiciar Medica		1. Decedent's Name (First, Middle, La. Constance	Ridgely		2. Date of Death Month	Day Z Year 3. Time of Death
Examine		4a. Facility Name (if not institution, give Genesis Re	e street and number) andalls town Center	4b. City, Town, or Location of Death Randalls town		4c. County of Death
Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth	9 Birthplace (State or Foreign
Director ≧		Usual Residence of Decedent	30		X-7-1	
death with the Maryland items 23a or 28a-f sho ner must be notified at	ector	10a. State 10b. County	Balti			10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h the M Ba or 28 be not	Funeral Director	10e. Street and Number	1 1	10f. Zip Code	10	g. Citizen of What Country?
eath wir	nne	3519 Wabas 11. Marital Status	12. Was Decedent Ever in U.S. 13.	Q1215 Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - American Indian,
in in the Science	2	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 Ves 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc. Specify: Black
215-0036 in 72 hours after e. han "netural", o	Completed	15. Decedent's E (Specify only highest gr	ducation 16a. Dece	dent's Usual Occupation kind of work done during most of work	king	ss. Kind of Business Country reach
2121 within 7 giene. er than , the Me		Elementary/Seconday (0-12)	Comege (1-4 or 5+)	Ceptionist	,	Center
yland Id be filed Mental Hyg arked oth	To Be	17. FAher's Name (First, Middle, Last) HTHULE	e Hatcher	18. Mether's Nan	ne (First, Middle, Ma	
Maryland 2 should be filed th and Mental Hy 27 is marked off traumatic even		19a. Informant's Name/Relationship (i	16	ing Address (Street and Number or Rui		
re, N 1 and 2 s f Health item 27 other tr		Vernon C. Kidge 20a. Method of Disposition	20b. Place of Dispo	osition (Name of	_	Oc. Location - City or Town, State
timo trent c trant: If		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	fy) Arbutus	Street 100 100 111	7-11 +	Arbutus, MD
Balty permit Depar Impor any in		21. Signature of Funeral Service Licen	Liere 2	2 Name and Address of Facility Co.	tip: K	neral Services e (21229)
		shock, or heart failure. List only of	pplications that caused the death. Do not entone cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	t, Approximate Interval Between Onset and Death
Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. Chronic Kidn Due to (or as a consequence of):	ey disease s	tage 4	Silos dia Bodiii
Examiner	e.	Sequentially list conditions,	b. Due to (or as a consequence of):	Hypertension		
uted ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events	c. Congestive Due to (or as a coblequence of):	Heart fail	hire	
be executed	<u> </u>	resulting in death) Last	Due to (or as a codequence of): Atrial Fi	brilation		
760 icate g phys s the	ğ		d			
Division of Vital Records, P.O. Box 68760 For the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
P.O.	y Ph	Part II. Other significant conditions	contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
rds,	sted t	Hyperthyr. Encephalo	oidism			s 2 🔀 No 3 🗆 Probably 4 🗆 Unknown
Division of Vital Records, sal or Attending Physician: The law requires s after death. I Director: After this certificate has been signed in by the funeral director, page 2 should be seen in the funeral director, page 2 should be seen in the funeral director.	omple	Encephalo	pathy		24a. Was an autopsy perform	prior to completion of cause of death?
tal cian:	Be	25. Was case referred to medical examiner?		26. Place of Death (Che	ck only one)	
Physic this c	<u>و</u>	1 ☐ Yes 2 🗷 No 27. Manner of Death	Hospital: 1 Inpatient 2 ER/Outpatie 28a. Date of injury 28b. Time of		lome 5 Resider	nce 6 Other (Specify)
On O	ficate	1 Natural 5 □ Pending 2 □ Accident □ Investigation	(Month, Day, Year) injury	work? M 1 Yes 2 No	25d. Describe nov	mjury occurred
jivisi II or Atte after de Directo	Certi	3 Suicide 6 Could not I 4 Homicide determined		reet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
Division To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical Certificate: To Be	(Check 2 Medical Exam	visician: To the best of my knowledge, death niner: On the basis of examination and/or inverse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred	at the time, date and	d place, and due to the cause(s) and manner state
To the within Comp.		29b. Signature and title of certifier	t imp	29c. License number D 7 1 4 9 3		Od. Date signed (Month, Day, Year)
8		30. Name and address of person who Farah Bozor			llatow	MO 21133
State Registra	-	31. Date filed (Month, Day, Year)	32. Redistrar s Signature	harles		
negistra		NUVU4	LUII Serom P. 7			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 5.45 PM ALEXANDRA RUSSELL 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Keswick Baltimore None 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs, 8 Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Days 213-03-8903 08723*P*1909 coMaryland Director 102 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County Director 10c. City. Town or Location 10d. Inside City Limits XX Yes 2 No Maryland None Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 West 40th Street 21211 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XX 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3XX Widowed 4 ☐ Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Alexander Russell IV Anna Blanche Purnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Russell Purnell Rich Son 902 West Northern Parkway Baltimore, Maryland 21210 thod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery 11/08/2011 |Pikesville, Maryland ☐ Donation 5 ☐ Other (Specify) gnature of Furferal Sery 22. Name and Address of FacMitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one of use on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Endstage arteriorcleristic cardinus cular disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the knoral director, page 2 should be detached for use as the burial-transit completed filled in by the knoral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 D No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ė 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No Accident Investigation M Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number Medical 1 👱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) N Habelle D13657 November 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OT ISABELLE TREGRESOR 700 W. 40th STREET, BALTIMORE, 570, 21211 31. Date filed (Month, Day, Year) State 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

11-08132	
Judith Xiomara Rivas	

ludith Xiomara	Riv	as State C 1-For State Registrar	of Maryland / Depa Ce	artment of ertificate of		l Mental F		eg. No. 2011	35250
Physic Medical Exam		1. Decedent's Name (First, Middle,Last)	omara	Pi	105		Date of Dea Month	ith Day Year	3. Time of Death 0705 hrs
		4a. Facility Name (if not institution, give		1011	b. City, Town, or L	ocation of Deat	October 3	4c. County of Death	
Funeral	H	University Hospital 5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	Baltimore If Under 1 Year	If Under 24Hr	s IB Date of Bir	rth(MM/DD/YYYY) 9. Bir	/+ tholace (State or
Director		unk _	M 2 F	26 Yrs.	Months Days	Hours Mir	_	Eoroic	
Any		Usual Residence of Decedent 10a. State 10b. County	110c. City	, Town or Location			11 (00)	<u> </u>	10d, Inside City Limits
	5	MD Balti	MMo	MILOC	Sor	Mi	15		1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number			10f. Zip Code	1.1		0g. Citizen of What Cour	ntry?
with the is 23a o	밀	3145 KIPPI 11. Marital \$tatus	12. Was Decedent Ever in U	J.S. 13. Was	Decedent of Hisp	244 panic Origin? (S		El Salva 14. Race - Ameri	can Indian, Black,
r death or item must b	Funeral	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No	If Ye	es, specify Cuban,	Mexican, Puerto		White, etc.	
hours after death with the Maryland batural", or items 23a or 28s-f she Examiner must be notified at once	à	3 Widowed 4 Divorced II 15. Decedent's Education (Specify only	f Yes, Give Year or Dates: y highest grade completed)		Yes 2 No	, ,	work done	Specify: VI	ndustry
2 -	lete(Elementary/Secondary (0-12)	College (1-4 or 5+)	0	est of working life, I		tired)	- 10	
5-0036 led within Hygiene. other tha	Completed	17 Father's Name (First, Middle, Last)			ishie		e (First, Middle, I	Maiden Surname)	service.
21215-0036 uld be filed within 72 hours afte Mental Hygiene, marked other than "matural", c event, the Medical Examines	Be		r nande:			Dor	a K	Livas	
	<u>۵</u>	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing	Address (Street	and Number or RCI	Rural Route Num	nber, City or Town, State	Zip Code)
2 2 2 5		20a. Method of Disposition 1 Burial 2 Cremation 3	_	Place of Disposit crematory or other	tion (Name of ceme er place)	etery,	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages I as Department of He Important: If ite		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	巨	vergre	eme and Address	of Engility	5/2011	Finksbu	ug, MU
Balti permit. Departm Importa		Willie C	Housell, &	2 107	220 Gru	1 ford	well.	_t-unula	MD 20194
Physician /Medical		23a. Part I. Enter the disease, or complic failure. List only one cause on each	n line.	n. Do not enter the	e mode of dying, s	uch as cardiac o	or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and
Examiner			lultiple Injuries ue to (or as a consequence o	of):					Death
	er	Sequentially list conditions, b if any, leading to immediate Du	ue to (or as a consequence o	of):					
	aminer	cause. Enter Underlying Cause	ue to (or as a consequence o						
0, be executed sician and ourial - transit	al Ex	d.							
50, te be executed ysician and burial - transit	ledical		AMENDED					02d Date of deliver	
Ox 6876(eath certificate sattending phy-	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg 1 Live birth	2 Feta	al death 3	Ectopic pregna	ancy	23d, Date of delivery Month D	ay Year
Box 6876 e death certificate the attending phy ed for use as the	Physician/M	1 Yes 2 No 9 V Unknown	Pregnant at time of de Unknown	eath 5 Othe	er (Specify)				
ires that the signed by I be detache	by PI	Part II. Other significant conditions co	ontributing to death but not re	esulting in the un	derlying cause giv	en in Part I.		bacco use contribute to	
rds, requires been sig	eted						24a. Was a	an 24b. Were au	topsy findings available
Division of Vital Records, tal or Attending Physician: The law requiring after death. To Director: After this certificate has been sided in by the funeral director, page 2 should be the funeral director.	Completed	•					autop: perfor	med? death?	ompletion of cause of
ital Recician: The sector, page	BeC	25. Was case referred to medical examiner?	spital: 1 Innetion 2		10	of Death (Check			
ing Phys After this funeral di	2	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time of Inj			28d. Describe h	Residence 6 Other	
Sion Attendir death. ctor: A y the fu	atio	1 Natural 5 Pending 2 Accident Investigation		FOUND: 0545 hrs		s 2 🗸 No		estrian struck by m	
Divis pital or A ours after teral Dire	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he (Specify) Major Road		, factory, office bui		or Town, St	Street and Number or Rui tate) Balt Co Line,Ellicott(
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	edical C	29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: O	: To the best of my knowledge on the basis of examination a	ge, death occurre		and place, and	due to the cause	e(s) and manner as state	ed.
To Too	Me	29b. Signature and title of certifier	nd manner stated.		29c. License	000	ME	29d. Date signed (Mor	
		The low M.	Ky JR	(March	O.C.M	.E. 001	E & Appag	October 31, 2011	
_		36. Name and address of person who con Theodore M. King, Jr., MD.	npleted cause of death (Item Assistant Medical E	•	00 W. Baltimo	ore Street, B	altimore, MD	21223	
St Regist		31. Date filed (Month, Day, Year) NOV 0 4 2011	32. Registrar's Signatu	barre	,				

11-08124 Sarah Emily Rober	1	on St - For State	pe or Print in late of Marylan	d / Depa		Health a		łygiene	egible.	3525
Physician Medical Examine	1	Decedent's Name (First, Middl	^{lle,Last)} Sarah	Emily	Rober	tson		2. Date of Dea Month October 2		3. Time of Death 1747 hrs
		4a. Facility Name (if not institution Anne Arundel Medical		per)		h. City, Town, o	or Location of Deat		4c. County of De Anne Arund	
Funeral Director		5. Social Security Number 215-31-9264	6. Sex 7.	Age (In yrs. la 23	st birthday) Yrs	If Under 1 Ye Months Da			irth(MM/DD/YYYY) 9. For	Birthplace (State or eign MD Country)
land f show any once.	ľ		Arundel	10c. City,	Town or Locat	Edg	ewater		10g. Citizen of What C	10d. Inside City Limits 1 X Yes 2 No
the Maryland sa or 28a-f shortfied at once		10e. Street and Number 1739 Tacoma	Road			10f. Zip Code 2 1	037		USA	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland depertment of Health and Mental Hygien. Important: I filem 21's marked other than "matural", or items 23s or 28s-f show injury or other traumatie event, the Medical Examiner must be notified at once. TO Be Compileded by Finneral Director		3 Widowed 4 Div	12. Was Deced Armed Ford 1 Yes vorced If Yes, Give Year or Dates:	es? 2 X No	1	es, specify Cub		o Rican, etc.)	White, etc Wh Specify:	nite
5-0036 ed within 72 hours lygiene. other than "natur the Medical Exam	nasaidiii	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12	College (1-4		during m	t's Usual Occupost of working li tudent	ation (Give kind of fe. DO NOT use re	tired)	16b. Kind of Busines	ss/Industry
215-0 be filed w mtal Hygie riked othe cent, the N		17. Father's Name (First, Middle, Timothy Da	avis Rober	tson					Maiden Surname) Hardgrave	36 <u>366101</u>
AD 21: 2 should 1 1 and Mer 27 is mar matic ev	2	19a. Informant's Name/Relations Timothy Robert	ship (Type, Print) tson /Fathe	r	19b. Mailing	Address (Str Tacoma	eet and Number or Road, Ed	Rural Route Nu gewater	imber, City or Town, St , MD 21037	ate, Zip Code)
imore, had Pages I and ment of Health lant: If item or other frau		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other S	pecify:	State Ch	erematory or other and the sapeak	ition (Name of oner place) .e CYeMa	tory 11	Date /2/2011	Beltsvi	lle, MD
Balt permit. Depart Impor injury	k	21. Signature of Funeral Service	Clearsh	all		PO BO	and Crema x 1413, I	ation Se Baltimor	ervices e, MD 2120	
Physician Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. Mixe	d drug(nzapri:	(Oxycod ne)Toxi	one,Tra	g, such as cardiac mado1, Zo	or respiratory at Lpidem a	and	Approximate Interval Between Onset and Death
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a c.	n sequence of	7):					
₩ I	ŭ	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co							
68760, ertificate be execuding physician and e as the burial - tr	200	UNPENDED	AMENDED 2		_	er me,g	921 11-2	1-11 sm	23d. Date of deli	verv
Box 68760, e death certificate by the attending physical for use as the burner of for use as the burner of the certification.	Physicianiw	IF FEMALE: (3b. Was decedent pregnant in topast 12 months? 1 Yes 2 No 9 ✓ Un	the 1 Live birt	h at at time of de	2 🔲 Fe	tal death (Specify)	Ectopic preg	nancy	Month	Day Year
b, P.O. Baires that the designed by the	Dy Fn	Part II. Other significant condi	itions contributing to c	leath but not re	esulting in the o	ınderlying caus	e given in Part I.			e to the cause of death? Probably 4 Unknown
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 44 hours after death. Funeral Director: After this certificate has been signed by the attending physician and their filled in by the funeral director, page 2 should be detached for use as the burial - transition of the property of the printing of the property of the	Completed							perl		
certifica cector, pa	2 -	25. Was case referred to medica examiner?	Hospital:	ation:	EDIO de die		ce of Death (Chec	k only one)		ther:
of Viving Physical Control of Vivine Control C	앜	1 Yes 2 No 27. Manner of Death	28a. Date of	Injury	ER/Outpatient 28b. Time of	njury 28c. Ir	ijury at Work?	28d. Describe	e how injury occurred	
Division of Vital tal or Attending Physician: as after death. al Director: After this certified in by the funeral director.	Certification	2 X Accident Inve	estigation fd 10-	29-11	fd 4:45	pm 1 et, factory, offic	Yes 2 No			medications Rural Route Number, City artstone Ct.
Division fospital or Attent thours after death uneral Director: ly filled in by the		4 Homicide dete	ermined (Specify)	Found	l:Resid	ence		Annapo	lis,MD.	
n 24 h		29a. Certifier 1 Certifying P	Physician: To the best of	of my knowled	ge, death occu	rred at the time,	date and place, a	nd due to the car	use(s) and manner as te and place, and due t	stated. o the cause(s)

DHMH 17 Rev 1/2001 OCME 2006

Registrar

29b. Signature and title of certifier

Russell Alexander MD.

State 31. Date filed (Month, Day, Year) istrar NOV 0 4 2011

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

ORIGINAL

OCME

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

October 30, 2011

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
AMEND ITEM#1perPHYS#20a-c,22perFH,G921,11/30/2011,WS
State of Maryland / Department of Health and Mental Hygiene
amend #19a Per FH G922 12/21/2011 JH
Certificate of Death
Reg. No. 2 | | For State Registrar Decedent's Name (First, Middle, Last)
Carol Roes 2. Date of Death 3. Time of Death Physician/ 2011 16, 2:37 PMM October Carol Rose Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ocean City Worcester 301 Nautical Lane 5. Social Security Number unk 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min (Month, Day, Year) Months unk Director 1 M 2 XF Apr 30, 1964 47 28a-f show 10a. State 10b. County 10d, Inside City Limits 10c. City, Town or Location Director notified 1 Yes 2 X No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö must be Funeral 23a 21842 USA 301 Nautical Lane items death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 N No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the own home housewife unk unk other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Jean Collison Earl Collison Heinza's koes/spouse Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 301 Nautical Lane Ocean City, MD 21842 Department of Health ar Important: If item 27 is any injury or other trau 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 11-04-2011 Glen Burnie, MD Other (Specify) in state Atlantic Crem 4 Donation Stanticity Cremerna Service Thomas Allen Pt.A. Baltimore, MD 21201 7090 Ridge Rd Hanover, MD de, Director Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Anset and Death motorfatre Immediate Cause (Final Ph.sician/ 6 me disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Due to (or de a consequence of): Examir burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an , page 2 s autopsy performed? Yes 2 No has death?
1 Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 Tyes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury 1 Natural work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completely filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Turce Fractitioner To the best of my knowledge, seath occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 26/ 2011

State

Registrar

CHERON ST SHLISBURY

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Month, Day, Year)

04

		For				nd / D	epart		Health and			0.1.1	05050		
		Registrar 1. Decedent's Name (First,	Middle La	c#)			Certii	ficate of	Death	2. Date of De	Reg. No.	UII	35253	_	
Physicia /Medic		NANCY	viidaio, La	317			RI	CHMOND		Month NOVEM	Day	2011^{Year}	05:10P M		
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Funeral Director		5. Social Security Number 219–18–3724		ex □M2XIF	7. Age (In yı			lonths Days		(Month, Da	/1924	9. Birti	hplace (State or Foreign untry) MD		
and w		Usual Residence of Decede 10a, State 10b, Co			10c. (City, Town	or Locati	ion					10d. Inside City Limits	-	
after death with the Maryland or items 23a or 28a-f show	ğ		/A								1 🖾				
r 28a-f	Director	10e. Street and Number	/ A			BALTI		10f. Zip Code			10g. Citizen	untry?	\dashv		
th with 23a or	a D	3031 FALLST	AFF I	ROAD, #3	304			2120	9	i		USA			
ems a	Funeral	11. Marital Status		12. Was Dece	Vas Decedent Ever in U.S. 13. Was Armed Forces? 15.			Decedent of	Hispanic Origin? (S	pecify Yes or No		Race - Ame Black, White			
	þ	1 ☐ Never Married 2 ☐ 3 🛣 Widowed 4 ☐ Div		1 □Yes 2ÑNo				If Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yes 2 💆 No Specify:				ecity:	White, etc. JHITE		
"natural"	eted	15. Dec	edent's Ed	ducation ade completed)				t's Usual Occi	upation e during most of wor	kina	16b. Kind o	of Business/	Industry		
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permit. Pages 1 and 2 should be filed within Department of Heath and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, ITEM once.	O	17. Father's Name (First, Mi	ddla Last					HOME	MAKER 18. Mother's Nar	no (First Middle		OWN HO)ME	-	
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should and Men s marke umatic	유	19a. Informant's Name/Rela	ationship (Type, Print)				Address (Stree	et and Number or Ru		er. City or To		<u> </u>	-	
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is 1 a		20a. Method of Disposition			20b	. Place of	Disposition	on (Name of ory or other pl	1	Date		on - City or			
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permit. Departr Importa any Inju		21. Signature of Funeral Se	rvice Licer	isee	,		22. N	ame and Add	ress of Facility SO					_	
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the at	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4 ☐ Pregr 9 ☐ Unkn	nant at time o own	f death	5□0	ther (specify)				MOTH	Day Year		
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- U -	ō -	29b. Signature and title of co						200 Lines	nse number		20d Dates	igned (Mont	h Day Voari		

State Registrar ATIMA ALI MAG 31. Date filed (Month, Day, Year) NOV 0 4 2011

HMH 17 Rev 1/2001

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FILM A ALI WARNI, MD 6334 CEDAR LAWE, LORIEN, COLUMBIA, MD 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 23a per dr., g921, 11/04/2011dhb Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 201 vevembe /Medical 4b. City, Town, or Location of Death 4c. County of Death Name (If not institution, give street and number Examiner Johns Hopkins Bayview Medical Center **Baltimore** 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. **Funeral** 1 □ M 2 🕱 F 216-54-2991 60 19-195 Yary Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show must be notified at 1 Yes 2 4 Director al/c 28a-f 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ò 23a 21222 Funeral Pages 1 and 2 should be filed within 72 hours after death items ; 14. Race - American Indian Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 1 ☐ Yes 2 ¶
If Yes, Give
Year or Dates: 1 Never Married 2 Married 2 No ō 21215-0036 1 ☐ Yes 2 XNo Specify: Black ģ 3 Widowed 4 Divorced "natural", Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education the Medical (Give kind of work done during most of working life. DQ NOT use retired) (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4 or 5+) aborer 18. Mother's Name (First, Middle, Maider 17. Father's Name (First, Middle, Last) Baltimore, Maryland ont of Health and Mental H
t; If item 27 is marked oth
y or other traumatic even Be 1 ar eward မ 19b. Mailing Address (Street and Number 19a. Informant's Name/Relationship (Type, Print) 20603 6158 20a. Method of Disposition 20b. Place of Disposition (Name of 1 M Burial 2 Cremation 3 Removal from State Department or Important; If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 1701 Assed the death. Do not enter the mode of dying, such as cardinach line. Approximate Interval Between Photo and Death 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause disease, or complications the Acute Myocardial Infarction Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical consequence of Examiner Sequentially list conditions, if any local state of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the IF FEMALE: 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ☐ Live birth 2 ☐ Fetal death 3 - Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Unknown 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 2 No 1 🔀 Yes Be 25. Was case referred to medical 26. Place of Death Check onl one Other: Hospital: 2 🗆 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 Other (Specify) Inpatient မ After this -28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? of Death Certification: 5 Pending investigation Natural within 24 hours after deau..

To the Funeral Director: After 1 ☐ Yes 2 ☐ No ccident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier VID who completed cause of death (Item 23a) (Type, Print) 30. Wame and address of person 4940 Eastern Avenue, Baltimore, MD, 21224

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-08218 State of Maryland / Department of Health and Mental Hygiene Joseph Walter Skipper Certificate of Death 1. For State Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 2, 2011 2008 hrs Joseph Skipper **Medical Examiner** 4b. City, Town, or Location of Death 4c, County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 317 East North Avenue Apt 311 If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 11/09/1959 AR Director Country) 218-78-1240 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No MD Baltimore es 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 317 East North Ave. 21202 USA 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Never Married 2 Married 1 Yes 2 No SpecifyWhite 1 Yes 2 No specify: If Yes, Give Year 1977 - 78 3 Widowed 4 X Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Hair Industry **Baltimore**, MD 21215-0036 Barber 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ James A. Skipper Julia Patricia Walsh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Julia McDonald/Mother 405 Palm St. Hamlet, NC 28345 If item 27 20b. Place of Disposition (Name of cemetery, Date 20c Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State Nov. Beltsville, MD rtant: Chesapeake Crem. Department 4 Donation 5 Other Specify: 2011 22. Name and Address of Facility AFA/Stephen D. Lohrmann P.A. 21. Signature of Funeral Service Licens MO1585 8717 Green Pastures Dr. Balto. MD 21286 Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Methadone and Morphine Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and . transit AMENDED 23a,27,28a-f,per me,g922 12-1-11 sm Physician/Medical signed by the attending physician at be detached for use as the burial -X UNPENDED Box 68760, 23d. Date of deliven IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Fetal death 1 Live birth 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part 1. Part II. Other significant conditions Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Š Completed 24b. Were autopsy findings available 24a. Was an certificate has been autopsy prior to completion of cause of performed? ✓ Yes 2 No death? 1 🗸 Yes 2 No page 26. Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical funeral director, Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 1 Natural 1 Yes 2 X No unknown Pending fd 11-2-11 fd 8:00 pm the 2 Accident 28f. Location (Street and Number of Rural Route Number, City or Town, State) Found: 31 / East North Ave. apt 311 Baltimore, Md. Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 3 Suicide 6 X Could not be Found: Residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Will Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 명 and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 3, 2011 O.C.M.E. 30. Name and address of person who completed cause of death/(Item 23a)

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

Russell Alexander MD.

ORIGINAL

Ssistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 35256 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Smith 4:22 AM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** Maryland Medical Center 4b. City, Town, or Location of Death 4c. County of Death University Baltimore Şex 8. Date of Birth OCt. 16, 1959 **Funeral** 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **1**₹ M 2 □ F Days New York Months Hours Director 122-50-6693 52 Usual Residence of Decedent 28a-f show 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Maryland 1 Yes 2X No Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with 614 Aspen Lane 21040 USA 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 🛣 No If Yes, Give 1X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates I Hygiene. other than "natura ent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver State Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental 27 is marked of traumatic ever မ Robert Michael Smith Barbara Ann Rodrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Barbara Hull / Mother 614 Aspen Lane, Edgewood, Maryland 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/4/2011 ↓ Dionation 5 ☐ Other (Specify) Jarrettsville Cem. Jarrettsville, Maryland . Sign 22. Name and Address of Facility 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Raod, Abingdon, Maryland 21009 23a. Part 1. Enter ne dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he it failure. List only one cause on each line. Approximate Interval Between Immediate Cause (First Onset and Death Physician/ Pancreotic Cancer disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): requires that the death certificate be executed use as the burial-transit Cause (Disease or rinjury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day Year g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy or Attending Physician: The this certificate Yes 2 N of Vital filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 No 1 🔀 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No To the Hospital or Attending F within 24 hours after death.

To the Funeral Director; After it 28d. Describe how injury occurred 1 Natural 5 Pending Division 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my kill. Whogo, does not occurred at the time, date and place, and due to the cause(s) and manner as etalled. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1659670214 11 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Britton 21201 12 S. Greene St. MD JUSTIN Baltimore 31. Date filed (Month, Day, Year) Registrar's Signature State NOV 04 Registrar

				or Print in Black Indelible Ink. Ensure A	_
			1 - For State Registrar	e of Maryland / Department of Health and M Certificate of Death	lental Hygiene Reg. N2 0 1 1 35257
	Physicia Medic		1. Decedent's Name (First, Middle, Last)	Swann	2. Date of Death NOVEMBER 1 2011 5:57 P M
	Examin	er	4a. Facility Name (if not institution, give street and GREATER BALTIMORE M	, , , , , , , , , , , , , , , , , , , ,	4c. County of Death BALTIMORE
T	Funeral Director		5. Social Security Number 2.2.3 - 36 - 35 98 Usual Residence of Decedent	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Yrs. Months Days Hours Min.	8. Date of Birth 8 North, Day, Year) 9. Birthplace State or Foreign Control 10 11 11 11 11 11 11 11 11 11 11 11 11 1
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	ector	10a. State 10b. County	10c. City, Town or Location	10d. Inside City Limits 1 ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑ ↑
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0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ted by	If Yes,	fes 2 No	Specify: Black
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	and 2 shou Health and :em 27 is m ither traum		19a. Informant's Name/Relationship (Typ), Pfin		Houte Number, City or Town, State, Zip Code) Aue Problem 2/2/8
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	North		29b. Signature and title of certifier	Of 11 D 29c. License number	29d. Date signed (Month, Day, Year) NOVEMBER. 2, 2011
	1		30. Name and address of person who completed of	cause of death (Nem 23a) (Type, Print)	NOVEMBER 2,2011 Les ST STE 650 21200
	Stat Registra		31. Date filed (Month, Day, Year) 3	2. Registrar's Signature	2, -, -, -, -, -, -, -, -, -, -, -, -, -,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 26 per doc g921 11-4-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month Physician/ Myrna J. Smothers 2011 Medical 11:30a 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Health Care Dundalk Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 T Months Days Hours Min. (Month, Day, Year) Yrs Director 219-28-4834 78 10 Usual Residence of Decedent 3a or 28a-f show t be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director 1 X Yes 2 ☐ No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2730 Giles Road 21225 U.S.A. must 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☐ No Specify. Specify: Black 3 Widowed 4 X Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City than, Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha the 12th grade na Teacher Public Schools Substitute traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Clara Johnson Rodger Moulden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valerie Smothers-Granddaughter 2730 Giles Road, Baltimore, Md 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/26/2011 On-Site Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Eacility March F/H West 4300 Wabash Ave, Baltimore, poin 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Debulut Medical Due to (or as a consequence of) Examiner Dementica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a colleaguereaut) The law requires that the death certificate be executed as the burial-transit Cause (Disease or liniury and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No jo Day Pregnant at time of death be detached 1 ☐ Yes ← 2 9 ☐ Unknown Linknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Hypertensia should Were autopsy findings available prior to completion of cause of death? 24a. Was an Diebetes autopsy performed? Yes 2 No certificate has page 2 1 Yes 2 No 25. Was case referred to medica To the Hospital or Attending Physician: funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 2X No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home -5 X Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 ★ Natural 5 Pending iniury M 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) more an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4105 Raltman MD 21204 47011N Lewis, 31. Date filed (Month, Day Year) 32. Registrar's Signature State Berlow

Registrar

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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of Hear of Hear fitem		20a. Method of Disp	oosition	Removal from State	20b. P	lace of Dispo	sition (Name of natory or other pla		Date	20c. Location	on - City or	Town, State	_
t. Page tment tant: I		4 Donation	5 Other (Spec	ify)		stlawn	Mem. Ga	rdens 11/				ille, MD	
permil Depar Impor any in		21 Signature of Full	neral Service Licer	A A	. мо		. Name and Addre 313 Talb	ess of Facility Denu-				ome, P.A.	
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Physician/		Immediate Cause (disease or conditio	Final		erstin	tial Pu	Imonora	Fibrosi	<u> </u>			Onset and Death	
Medical Examiner		resulting in death)	•	Due to (or as	a consequ	rence of):							
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eath certificate be executed attending physician and for use as the burial-transit	ਰ	resulting in death) l	Last	d.	a consequ	ionico onj.							
tificate ng phy as the	Medi	IF FEMALE:		- u									_
ath cert attendii for use	Completed by Physician/Medic	23b. Was decedent in the past 12 r	months?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	ıl death 3 🛚	Ectopic pregnan Other (specify)	су			Date of deli Month	ivery Day Year	
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requires that the de been signed by the should be detached	by P	Part II. Other signif	1	contributing to death b								the cause of death?	
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ian: Ti ertificat ctor, pa	Be C	25. Was case referre	ed to medical				26. F	Place of Death (Chec		S mainol		242110	_
Physic this or	은	1 Yes 2 2		Hospital: 1 1 Inpati		ER/Outpatier	nt 3 🗆 DOA		ome 5 Resid			ify)	
nding ath. r: After e fune	Certificate:	1 ☑ Natural 2 ☐ Accident	5 Pending Investigation	(Month, Da	y, Year)	injury	wor		Zod. Describe n	ow injury occ	uneu		
or Atte fter de irecto n by th	ertif	3 Suicide 4 Homicide	6 Could not determined				eet, factory, office		28f. Location (S City or Tow		mber or Rur	ral Route Number,	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director, After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the but		29a. Certifier 1	Certifying Ph	ysician: To the best of	my knowl	edge, death	occured at the time	e, date and place. a	nd due to the car	use(s) and ma	anner as sta	ited.	
To the Hospital or Attending Physician: The law within 24 burus after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Medical	(Check 2 only one) 3	☐ Medical Exan ☐ Certifying Nu	niner: On the basis of e rse Praptioner: To the	examination	n and/or inves	tigation, in my opin	ion, death occurred a	t the time, date a	nd place, and	due to the o	cause(s) and manner st	ated
With Voir		29b. Signature and	title of certifie	11	MC	>	29c. Licens			29d. Date sig	ned (Month		
,		30. Name and addre	ess of person who	completed cause of c	death (Item	23a) (Type. F	Print)	6722	>	11"	1 - 6		_
>√		Marc	Gibbe	5 22	5.	Greene	- 1	Balt none	MD	21	105		
Stat		31. Date filed (Mont	h, Day, Year)	2. Registr	ar's Signat	ture	1.1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Octobe 10:05 PM SEWARD BAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Laurel Regional Hospital Laurel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** Year) 937 Country)
Tennessee 1 🗆 M 2 🕱 F Months Hours June I. 74 Yrs **Director** 406-46-5645 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland **Funeral Director** Examiner must be notified 1 Yes 2 X No MD Anne Arundel Laurel 10e, Street and Number Ь 10f. Zip Code 10g. Citizen of What Country? 23a 3498 Old Annapolis Road 20724 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married o, ò Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: White 3 Midowed 4 □ Divorced 'natural" Specify: Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 9th Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Lehr Wilkerson Ruby Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa M. Nicklow/Daughter Millfield Court, 8210 Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crem. 11/2/2011 Odenton, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, 23a. Part 1. Euter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Sepsis Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Tract Infection Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at the detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed? Yes 2 XN 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 XInpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Medical Certificate: 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: /
completed filled in by the f Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and 29d. Date signed (Month, Day, Year) 29c. License number D55861 7300 Van Dusen Road 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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32. Registrar's

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35261 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10727/2011 VINCENT N. SILVESTRI 9:30 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD 2405 DERBY DRIVE **FALLSTON** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Sex 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)}1934 Days Hours Min 1XX M 2 - F July 19 Country 1and 216-30-6636 77 Director Usual Residence of Decedent 28a-f show 10b. County ms 23a or 28a-f sho must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits with the Maryland Director 1 Tes 2 MD Harford Fallston 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2405 Derby Drive 21047 US items be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian the Medical Examiner Armed Forces? Black, White, etc. ò þ 1 Never Married XX Married 1 Yes 2 If Yes, Give Year or Dates 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sears Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H 2 **Silvestri** traumatic Nicola. Margherita Paniccia t. Page 1 and 2 should by treet of Health and Mertant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie Silvestri (Wife) 2405 Derby Dr. <u>Fallston, MD</u> 21047 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl once. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/01/2011 Glen Burnie, MD 21. Sign vue of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of Bel Air 610 West MacPhail Road, Bel Air, Maryland 21014 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. ementon disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) and Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death signed by the at d be detached for Unknown Hospital or Attending Physician: The law requires that the 24 hours after death.
 Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 performed? 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ပ္ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manna of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No Investigation Accident Accide filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 988

DHMH 17 Rev 7/2009

State Registrar MARCHAIL BULAIN MA 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 20<u>11</u> Garland Edward Shaffer 3:05P M Nov Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reisterstown Baltimore FutureCare Cherrywood 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Y Days Country) 1 🔀 M 2 🗆 F 215-26-1744 82 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director Westminster Carroll 1 X Yes 2 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21157 151 Ε. Main St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. 9 1X Never Married 2 Married XYes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify.white Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emma R. Smith Milton E. Shaffer permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 688 Blizzard Farm Ln., Westminster, MD Evelyn Miller-sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Meadow Branch Cem! Westminster, MD 11-7-11 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign are of where see it Licensee 21157 254 E. Main St., Westminster 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician a cu minutes disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine ensi or Attending Physician; The law requires that the death certificate be executed use as the burial-trans. and that initiated events resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has l autopsy performe 2 🗆 No 25. Was case referred to medical examiner? 1 🗌 Yes funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ဂ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 2 Acciden 3 Suicide work's 5 Pending 1 Yes 2 🗌 No Investigation Accident filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one 29d. Date signed (Month, Day, Year) 29b. Signature and titl 201 large and address of person wh completed cause of death (Item 23a) (Type, Prin RCCa 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

35264 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 27,2011 8:57A. M Anna Marie Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1116 Janice Court Joppa If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 215-112-9533 7. Age (In yrs. last birthday) **Funeral** Months Hours Maryland Director 88 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Harford 1 Yes 2 No Md. Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21085 USA 1116 Janice Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien, item 27 is marked other th 12 ch Home Homemaker event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Dash Frank Kern injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health al Important: If item 27 is any injury or other trau 21085 <u>William Thompson</u> 116 Janice Court Joppa, Md 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parkwood 10-31-2011 Parkville, Md. Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licens 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onest and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and attending physician Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
b Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day 4 Pregnant g Unknown Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1) and mits 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 002769 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OWALTHOR AVE

State

Registrar

NOV 0 4 2011

32. Registrar

State Registrar

10

29b. Signature

e filed (Month, Day, V 0 4 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

29c. License number

01069559A

29d. Date signed (Month, Day, Year,

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

2011

CTBC 930/PH Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 9:30 PM Douglas Field Wagner October 29, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot County William Hill Gardens Easton Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1√ M 2□ F Director 212-16-0639 94 07/13/1917 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐ Yes 2 ☐ No Maryland Talbot County Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene.
snt; If item 27 is marked other than "natural", or items 23a or Lry or other traumatic event, the Medical Examinar reust to a Funeral 21601 545 Cynwood Dr. Apt W-202 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2½ No ģ Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Computer Operator B&O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Howard M. Wagner, Jr. Elizabeth Mitchell 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna M. Wagner/ wife 10 2nd Ave, N Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important; If ite
any injury or ot
once. IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Denation 5 □ Other (Specify) Glen Haven Memorial 11/3/2011 Glen Burnie, Maryland 21. Sign the of ron, ral Service Licensee 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Highway SE, Glen Burnie, Maryland 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Hapiration /Medical Due to (or is a consequence of): Examiner Dysphyia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last COPD law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) of Vital Records, P.O. Tyes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an this certificate has page 2 autopsy performed? /es 2 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Ax + Living 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

DHMH 17 Rev 1/2001

State Registrar

ORIGINAL

10-31-11

29c. License number

29d. Date signed (Month, Day, Year)

RD77623

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas CRNP

545 Cynusual Dr Easten, MD 21601

31. Date filed (Month, Day,

THE Show CRAP

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Wotrner Month Virginia November 9:350 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Randallstown 4c. County of Death
Baltimore **Examiner** Seasons Hospice Social Security Numbe 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days July 20, 1929 173-24-1618 Director 1 - M 2 X F 82 Penn. 28a-f show 10a. State Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code or items 23a Funeral 8924 Allenswood Rd. 21133 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🛣 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 9 1 Never Married 2 Married 1 Yes If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 I h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) Momemaker Mousewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Karllo Michael Gaidos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 10906 Hammond Dr. Laurel, MD. 20723 Amy M. Woerner - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 Removal from State All Faiths Crematory Nov. 3,2011 Manchester, MD. 21102 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Eckhardt Funeral Chapel F.A. 21. Signature of Funeral Service Licer Elleb. 11605 Reisterstown Rd. Owings Mills, MD. 21117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Ph_sician/ Recta Lancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ate has been signed by the atter page 2 should be detached for in the past 12 months?
1 Yes 2 No Dav Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has performed?

Yes 2 No 2 No 1 Yes filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner 4 Nursing Home 5 Residence 6 Other Specify 4 Up 2016 1 ☐ Yes 2 ☑ No Hospital Other: <u>ا</u>د 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending work? 1 Yes 2 No 2 Accident Investigation within 24 hours after death To the Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number nsky warnem. D DO057465

DHMH 17 Rev 06-2011

6

State Registrar Bother MO

2835 Smith Acre

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, M.D

31. Date filed (Month, Day, Year)

11-08170
Karen Wheeley

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Caren Wheeley		1- For State Registrar	tate of Marylar		rtment of tificate of		a Menta		Reg	g. No. 20		35268
Physicia Medical Exami		1. Decedent's Name (First, Midd							Date of Death Nonth ctober 31			3. Time of Death 1645 hrs
		Karen Ann Whee 4a. Facility Name (if not institution	on, give street and num	ber)	4	b. City, Town, or	Location of		Clobel 31	4c. County o		
		333 Chimney Oak Dri				Joppa	T	- ii - I-		Baltimore		
Funeral Director		5. Social Security Number 213–58–3688	6. Sex 7	. Age (In yrs. Ia	st birthday) Yrs.	If Under 1 Yea Months Days	_	Min		1951 B, 1951	Foreign	
, and		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Location	on	_					10d. Inside City Limits
and show a	٦	Maryland Hari	Ford	Jog	ppa							1 Yes 2 No
Maryla 28a-f	Director	10e. Street and Number				10f. Zip Code			10	g. Citizen of Wh	at Count	try?
ith the Maryland 23a or 28a-f sho ootfied at ooce		333 Chimney (d	. [40.18/	21085		0/0	. V N-	USA	Ai	an Indian Rical
eath wi	Funeral	11. Marital Status 1 Never Married 2 M	arried Armed Fore	dent Ever in U.Sces? 2 X No		Decedent of His es, specify Cubar				White		can Indian, Black,
after d	J. F.	3 Widowed 4 Div	1 Yes /orced If Yes, Give Year or Dates:	2 <u> </u>	1	Yes 2 No	specify:			Specify:	Wh:	ite
5-0036 led within 72 hours dygiene. other than "natur the Medical Exami	ted	 Decedent's Education (Spe Elementary/Secondary (0-12) 	cify only highest grade			's Usual Occupat est of working life			done	16b. Kind of Bus	siness/In	dustry
36 thin 72 than '	Completed	Elementary/Secondary (0-12)	2	1013+)	Secn	etary				Medic	al (Office
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f she oot, the Medical Examiner must be corfifed at ooce		17. Father's Name (First, Middle					18.Mother's	Name (Fire	st, Middle, M	aiden Surname)		
21215-0036 wild be filed within 7 Mental Hygiene. marked other than e evect, the Medica	o Be	Francis Joseph 19a. Informant's Name/Relations			19h Mailing	Address (Stree						Kowalewski
→ 5 5 m m	٩	Charles Wheeley	, , , , ,	1	M/ P					- · · · ·		yland 21034
imore, MD 2 Pages 1 and 2 shou ment of Health and 1 taot: If item 27 is no or other traumatic		20a. Method of Disposition 1 Burial 2 Cremation				tion (Name of cer		Dar		20c. Location -		
Baltimore, Department of He Important: If it		4 Donation 5 Other S		ii State j	Litop S	ervice C	orp.	11/9/	2011			aryland
Baltimore, ME permit. Pages 1 and 2 si Department of Health ar Important: If item 27 injury or other trauma		21. Signature of Funeral Service	Licensee	, , , , , , , , , , , , , , , , , , ,		ame and Address						
Physician		23a. Part I. Enter the disease, or	complications that cau	ised the death.								and 21009 Approximate Interval
/Medicul Examiner	T	failure. List only one cause	Tree omt or	nsive Ca	ardiova	scular I	iseas	e				Between Onset and Death
XaIIIIICI		or condition resulting in death)	Due to (or as a c	onsequence of)):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of)):							
	Examiner	(Disease or injury that initiated events resulting in death) Last	c. Due to (or as a c	onsequence of)):				_			
ecuted and transit	Ě	- ·	d) T	- 17		1 11	10 11				
Records, P.O. Box 68760, The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	bdic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?				r me,g92	1 11-	18-11	. sm 			=
Box 68760, e death certificate be the attending physic ed for use as the bur	M.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou			al death 3	Ectopic	oregnancy		23d. Date of Month	delivery Da	ay Year
Sox 6876 death certificate e attending phy for use as the	Physician/N		known '-	nt at time of dea	44-	er (Specify)						
J. B.	Phy	Part II. Other significant condit	19 Olikilow		sulting in the u	nderlying cause g	iven in Part	l.	23e. Did tob	pacco use contril	bute to th	he cause of death?
F. P.O ires that t signed by	Completed by	Chronic Alcol	nol Abuse					_	1 Yes	2 No 3	✓ Proba	abiy 4 Unknown
of Vital Records, or Physician: The law requir Wher this certificate has been s meral director, page 2 should I	olete							Î	24a. Was ar autops			opsy findings available empletion of cause of
Reco The law cate has	E O							_	perforn 1 Yes 2		eath? Yes	s 2 No
Vital Rec yrician: The his certificate	Be	25. Was case referred to medica examiner?	Mossital:				of Death (C					
1 of Viting Physics. After this funeral directions	£	1 Yes 2 No 27. Manner of Death	28a. Date of		ER/Outpatient 28b. Time of In		y at Work?	Nursing Ho 28d.		Residence 6		Scene
C = 1 - 4	Ę	1 X Natural 5 Pend 2 Accident Inve	ding	Day,Year)		1 🗆 🗅	es 2 h	10				
Division pital or Attendir ours after death.	Certification:	3 Suicide 6 Cou	id not be	of Injury - At ho	me, farm, stree	, factory, office b	uilding, etc.		Location (St or Town, Sta		r or Rur	al Route Number, City
Div Hospital or 24 hours afte Fuoeral Dii tely filled in		4 Homicide	rmined (Specify)					- 1				
hin the	Medical	(Check only	hysician: To the best of miner: On the basis of	examination an								
To Witi	Mec	29b. Signature and title of certific	and manner state	ted.		29c. Licens	e number			29d. Date signe	d (Moni	th, Day, Year)
		Janel Four	hall, MD			O.C.	M.E.			November	1, 201 ⁻	1
2 opend	ļ	30. Name and address of person Pamela E. Southall, N				W. Baltimore	Street	Raltimor	a MD 21	223		
	ate		9			VV. Dailittol	oneer,	Januillo	U, WID Z I.			
Regist	rar	31. Date filed (Month, Pay, Year)	III Genera	strar's Signatur	gun							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	,	tificate of Death	Reg.	7011	35269			
	Physicia		1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	03 2011 I	3. Time of Death			
1	Medic Examin		Khalid Marion Will: 4a. Facility Name (if not institution, give street and		4b. City, Town, or Location of Deat		4c. County of Death	10.13 11			
مب			Envoy Of Pikesville Her	7. Age (In yrs. last birthday)	Pikesville If Under 1 Year If Under 24 Hrs	8. Date of Birth	Baltimore 9. Birthpla	ce (State or Foreign			
	Funeral Director		6. Security Number 6. Sex 1 N M 2	F 6/ Yrs.	Months Days Hours Min.		SO CARC	ce (State or Foreign) South			
7	show at	l. h	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	cation		100	d. Inside City Limits			
5	Maryla 28a-f s otified	irect	MD	B	ALTIMORE		1 X Yes 2 □ No				
44	23a or st be n	Funeral Director	10e. Street and Number 4302 GROVEIANI	AVE. APT 1	10f. Zip Code 21215	10g	Citizen of What Countr $\mathcal{U}_i S_i \mathcal{A}_i$				
4	items		11. Marital Status 12. Was D	Decedent Ever in U.S. 13. V	Vas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Americar Black, White, et	Indian,			
036	within 72 nours after ceatri with the inaryiario giene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	ed by	1 Never Married 2 Married 1 Never Married 2 Married 1 Year of 1 Year of 1 Year of 1 Year of 1 Never Married 1	les 2 VINO	☐ Yes 2 No Specify:		Specify: BLA	CK			
Maryland 21215-0036	"natul edical	Completed	15. Decedent's Education (Specify only highest grade comple	ted) (Give F	lent's Usual Occupation kind of work done during most of wo O NOT use retired)	rking 16	Sb. Kind of Business Indu	stry			
212	witnin / giene. er than the M		Elementary/Seconday (0-12) Colleg	e (1-4 or 5+) 134	NOT use retired)	_	elF-Emp				
pue	be filed and the sental Hyg ked oth ic event,	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Mai	den Surname)	•			
aryle	should b and Mer is mark raumatic		HAZEL WASHII 19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Number or Ri		ity or Town, State, Zip Co	de) 21215			
Σ,	and 2 St Health a tem 27 is ther tra		FLORENCE WILLAMS 20a. Method of Disposition	WIFE 4302			ALTIMORE, Dc. Location - City or Tow				
nore	ant. Page 1 and 2 should be filed within 72 hours after death with the waryland antenent of Health and Mental Hygiene. ordant: If fire Z7 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at e.		20a. Method of Disposition 1	20b. Place of Dispo cemetery, cren	natory or other place)	Date 2011 N	LARMORA,	New			
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ott		21. Sign more of Funeral Service Livensee	DEA SIVE	. Name and Address of Facility E	DERRICK	C. JONES	FIH, P.A.			
	<u> </u>	Н	23a. Part 1. Enter the disease, or complications to	hat caused the death. Do not enter			TIMORE, M	Approximate Interval Between			
-a P	hysician/		shock, or heart failure. List only one cause o Immediate Cause (Final disease or condition		Multiple mie	/cmd		Onset and Death			
man of	Medical Examiner		resulting in death) Due	e to (or as a consequence of):	1 ,			/			
		iner	Se juentially list conditions if any, leading to immediate cause. Enter Underlying	e to (or as a consequence oi):							
8	and -transi	Examiner	Cause (Disease or iinjury	e to (or as a consequence of):							
760	physician and the burial-transit	edical	d								
			IF FEMALE: 23c. If yes 23b. Was decedent pregnant	, outcome of pregnancy			23d, Date of delive	γ			
Box 68	Attending Physician; The law requires that the oeann cernic are death, as death. ector. After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	in the past 12 months?		Ectopic pregnancy Other (specify)		Month	Day Year			
P.O.	at the order of the detache		9 Unknown Part II. Other significant conditions contributing		underlying cause given in Part I.	23e. Did toba	acco use contribute to the	e cause of death?			
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cor	law rec has bee e 2 sho	Completed				24a. Was an autopsy perform	prior to cor death?	sy findings available npletion of cause of			
E Re	ician; The law certificate has rector, page 2 9	Be Col	25. Was case referred to medical		26. Place of Death (Ch	1 \(\text{Yes} \) 2	No 1 Yes	2 No			
Vita	inysician; his certific il director,	은		1 Inpatient 2 ER/Outpatie			ce 6 Other (Specify)				
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Ξ ;	Io the Hospital or Attending Fin within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral.	Medical C	29a. Certifier 1 Certifying Physician: To (Check 2 Medical Examiner: On the	the best of my knowledge, death	occured at the time, date and place stigation, in my opinion, death occurre	, and due to the cause	e(s) and manner as state	d. se(s) and manner stated.			
:	the Horithin 24 the Fu	Med	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practio 29b. Signature and title of certifier	ner: To the best of my knowledge,	death occurred at the time, date and	olace, and due to the c	ause(s) and manner as stand. Date signed (Month, L	itea.			
	- ≥ ⊭ ర		1		037573		November				
	A	10		sever of death (Itam 22a) (Type							
	A		30. Name and address of person who completed	2837 32. Registrat's Signature	S. Ah Are	Battin	e Mt .	21209			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dec 2. Date of Death 3. Time of Death Physician/ Month 7.30 1 TOP Medical 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Penos nide m 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Hours Min Director 1 🗆 M 2 📝 F 84 Usual Re or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No MD more 10g. Citizen of What Country? 10e. Street and Number must be Funeral 21229 items 23a USA nit. Page 1 and 2 should be filed within 72 hours after death vartment of Health and Mental Hygiene ortant: If item 27 is marked other than "natural", or items injury or other traumatic event, the Medical Examiner mu 12. Was Decement Ever in U.S Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. De NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) er's Name (First Middle Last) Bryant ပ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. ural Route Number, City or Town, State, Zip Code) 2 228 94. Informant's Name/Relationship (Daughter) 1109 iams umminas eronica Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State cemetery, crem 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart valure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ neumono disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off burial-transit attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? >pertengn 24a. Was an autopsy performe has 1 ☐ Yes 2 ☐ No this certificate Yes 2 N To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 ANO ER/Outpatient 3 DOA 1- Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at iniury 1 Natural 5 \square Pending work? Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, 28e. determined City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Land the land state of the lasts of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Lertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 03 2011 N ~ when 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 455 nale 2/229 31. Date filed (Month State Registrar NOV O 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State	of Mai	yland /	•	ırtmen tificate			and M	1ental Hy			1	352	7 1
			Registrar 1. Decedent's Nam	e (First, Middle,	Last)			Cer	incate	OID	eatri		2. Date of De		20	1 1	3. Time of De	
	Physicia Medic		Siu Fı	ın Wong	,								Month Octobe		3 ^y 1,	Year 2013		
	Examin		4a. Facility Name (if	not institution,	give street and nur	mber)			4b. City,	Town, or	Location of	of Death			. County o	of Death		
- John State of State			14103 C						Laur			0411-			rince			
	Funeral Director		5. Social Security N 213-98-7		6. Sex 1 □ M 2 🕱 F	7. Age (i	In yrs. last b 53		Months Days Hours Min.				8. Date of Bir (Month, Da	th ay, Year)		Cour		oreign
			Usual Residence	of Decedent	I L I WI Z LALF			Yrs.					Jan.11,1958			Hong Kong		
vland	f sho	ctor	10a. State	10b. County		1	0c. City, To		ation								10d. Inside City	- 1
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eath v	tems er mu	Funeral Director	11. Marital Status	OIN COL	12. Was Dec		er in U.S.	13. W	/as Deced	ent of His	spanic Ori	gin? (Spe	cify Yes or No-				can Indian,	\neg
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Maryland 2 should be filed	ed otl	To B	17. Father's Name (First, Middle, La n Cheun									e (First, Middle) Chunq	, Maiden	Surname))		
	nd Mei mark matic		19a. Informant's Na		J		J.	Ob Mailia	= A ddvaaa	(Stroot o			I Route Numbe	ar City a	r Town St	ata Zin	Cadal	
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ore,	of He fiter rothe		20a. Method of Disp		3 Removal from	Chata	20b. Place	e of Dispos etery, crem	sition (Nam	e of her place	, ,		Date 9 ,	20c. L	ocation -	City or T	own, State	
Baitimore, permit. Page 1 and	tment tant; jury o		4 Donation			rotate		aine	Park	Cem		Nov. 201	.1		timo			
Dear Permit	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fu	neral Service Li	censee	M0]	L053	22.	Name and	d Address	s of Facilit ott A	y Don ve.,	aldson Laure	Fun	eral D 207	Home 707	e, P.A.	
				rt failure. List or	complications that nly one cause on ea	caused thach line.	ne death. De	o not ente	r the mode	of dying	, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Betwe	en
	ysician/		Immediate Cause (disease or condition resulting in death)	Final on			eloje		Leul	emia	ì					- 1	Onset and Dea 12 month	ath 1S
	Medical xaminer		resulting in death)	1	Due to	(or as a c	onsequenc	e of):										
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onted	nd ransit	cami	Cause (Disease or that initiated events	injury	c													
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death o	he atte led for	Physician/M	in the past 12 r 1 ☐ Yes 2 ☐ 9XXUnknown	No		nant at ti	me of death		Other (sp					ŀ	Mor	nth	Day Yea	ir
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oding Pl	ith. : After e fune	cate	1 ☒ Natural 2 ☐ Accident	5 Pending	(Mor	ith, Day, Y		injury	M Z	3c. Injury work? 1 🔲 ۱	es 2 🗆	- (28d. Describe	now injui	ry occurre	a		
VISION or Attendir	er des rector I by th	Certificate:	3 Suicide 4 Homicide	6 Could n	ot be 28e. Place	of Injury	- At home,	farm, stre	et, factory	office			28f. Location (r or Rura	l Route Number,	
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e Hosp	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2	Medical Ex	Physician: To the back caminer: On the back Nurse Practitione	sis of exar	nination and	d/or investi	gation, in r	ny opinior	n, death o	curred at	the time, date	and place	e, and due	to the ca	ause(s) and mann	er stated.
To the	withir To th сотр		29b. Signature and		. 1-40	3	NI NI			License		Jana pia			ate signed			
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	Registra		NOV O	4 2011	Burney	1	bar	the state of										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ,2011 Julie Elizabeth Wilcox October 7:38P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Balto. Towson Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Director 1 □ M 2 □ XF 220-62-3049
Usual Residence of Decedent 42 October 6,1969 Maryland be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f Md. Harford 1 Yes 2 XNo Fallston or 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? must be Funeral 23a 2503 Munford Drive USA 21047 ıral", or items ? | Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: White 3 🗌 Widowed 4 🗆 Divorced Completed Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Appraiser Self-Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be.
Department of Health and Mental Important: If item 27 is markany injury or others. ည Jerome Debes Rosa Rueckert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wilcox III 2503 Munford Drive Fallston, Md. 21047 Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Date Donation 5 Other (Specify) 11-4-2011 Fallston, Md. Highview Memorial 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home, Inc. all 610 W. MacPhail Road BelAir, Md. 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Does to for the exponence common offiburial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Coxtifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 00071287 Name and address of person who completed cause of death (Item 23a) (Type, Print)
Willy Shahelu, 6701 N. Charles St. Suite 4105, Balthuall, Mi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 20:02 M Miranda Gloria Walters +obe: Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and numb 4c. County of Death Examiner Himore Hospita JOHNS 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Hours 658-47-8161 **Director** 1 🗆 M 2 🔀 F 9-29-2011 MD Yrs 29 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location aţ Director notified 28a-f 1 Yes 2X No MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Funeral 21157 USA 985 Hacienda Ct. items 2 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. "natural", or itel Armed Forces? Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Maryland 21215-0036 1 Yes Y No Specify If Yes, Give Specify: white Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Infant Infant n and Mental Hygier 7 is marked other t Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, ဂ္ Vincent Walters Lisa Restaino Page 1 and 2 should hent of Health and Me 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trauonce. Vincent Walters-father Hacienda Ct., Westminster, MD 21157 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-5-11 Westminster, MD Meadow Branch Cem! 22. Name and Address of Facility Fletcher Funeral Home 21. Signature of Funeral Service Licer 254 E. Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 400 -(1 05 Iva disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner (Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknow P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records. 1 Yes monar Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 ☐ Yes 2 Z Q o patient 2 ER/Outpatient 3 DOA မှ funeral (28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Anatural 5 Pending s after death. 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Medical 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, doct heavy and the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 0056680

State Registrar 30. Name and address

NOV 0

31. Date filed (Month, Day, Year)

N. WOIFE St

Baltimore

no completed cause of death (Item 23a) (Type, Print)

600

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 35275 Reg. No2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / Physician/ BY2 7:00 am IncenT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Harwood Mandrin House 8. Date of Birth (Month, Day, Year) 9. Birthplace (St. Country)

July 11, 1946 Maryland If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Numbe 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 1 M 2 D F Months Days Hours Min. **Director** 218-48**-**0032 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State Director 1 🗌 Yes 2 🛣 No Pasadena MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral **USA** 21122 805 221st Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates, 1966-71 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Manager other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Josephine Frances Weber Department of Health and Ment.
Important: If item 27 is marked any injury or art. Vincent Joseph Yuhanek, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 221st Street Pasadena, MD 21122 Margaret M. Yuhanek/wife 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) Final Journey Crematory 11/03/11 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer Going Home CRemation Service P.O. Box Beverly L. Heckrotte, P.A. Clarksville, MD 21029 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart folium. List only one cause on each line. Approximate Interval Between
Onset and Death
Mindel Immediate Cause (Final Physician/ SOULIMOUS disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Die to (or as a nonsequence of): If any leading to immedicause. Enter Underlying Examir Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death 5 Other (specify) signed by the a d be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No has this certificate Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: MANDRIN 2 🗹 No ပ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1
Yes 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 5 \square Pending injury 1 🗹 Natural 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 72360 and address of person who completed cause of death (Item 23a) (Type, Print)
LOW LUKAS, MD 445 Defense HWY, ANNAPOUS, MD 21401 30. Name LUKAS. MD Lou

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 35276 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Corrie Fowler Young 11:58 M 10 Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince <u>Fort Washington Hospital</u> Fort Washington Georges **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Months Days 250-52-1828 Min. Hours Month, Day, Year 28 Country) **Director** SC Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MDPrince Georges 1 Yes 2 I No Fort Washington 10e Street and Number 10g. Citizen of What Country? Funeral 10904 Hidden Creek Court USA 20744 permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black "natural", Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever မ Oliver Fowler Lillie Tinsley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 10904 Hidden Creek Court Mary J. Anthony Daughter 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Riverdale pk Crem 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale MD 11-04-201 Signature of Funeral Service Licensee 22. Name and Address of Facility 20746 TShe Cedar Hill FH,4111 PA Ave.,Suitland, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ theroscleratic disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 **X**No detached 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy the Funeral Director: After this certificate In pleted filled in by the funeral director, pag performed' 2 🗆 No 1 Yes 20 No 1 🗌 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 17 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury hours after death. 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c License number D0053117 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Livingston Rd., Ft. Washington, MD 20744-5164 Daly MD 11711 Patrick 31. Date filed (Month, Day, Year) 32. Registrar's Sig State NOV 0 4 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35277 For State Of Warylar State Of Warylar Registrar AMEND#5penFH, 10/24/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 7:56 P 2. Date of Death Physician/ Month 10/18/2011 Year Marie Elverine Arana Medical n. Facility Name (if not institution, give street and number) 12317 Old Canal Road Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Potomac If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 535-05-3989 1 □ M 2 🛣 F Days Hours Min Months 11/02/191 Director Kansas Usual Residence of Decede 28a-f shov than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Potomac 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral with 1 20854 12317 Old Canal Road United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ¥ No Specify 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working 72 should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Music Musician / Violinist traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Bayard Clapp Erma Lolelia Brooks-Reed permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. Victoria Arana-Robinson 12317 Old Canal Road Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 K Cremation 3 Removal from State Falls Church, VA 10/20/2011 4 ☐ Donation 5 ☐ Other (Specify) Crematory 21. Signature of Funeral S 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease or complication of at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. // st only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Thyroid Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir 9 burial fagisi Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed? death? certificate Yes 2 X No 2 🗌 No director. 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 XNo 12 Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 💢 Residence 6 ☐ Other (Specify) After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖾 Natural To the ruosporce.
within 24 hours after death.
To the Funeral Director: Afte 5 Pending work 1 Tes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) younpleted filled in by 4 Homicide determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death continued at the time, date and place, and due to the cause(s) and 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009 31. Date filed (Month, Day, Year)

Marcia Goldmark MD 15020 Shady Grove Rd. #300 Rockville, MD 20850

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D25348

10/20/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	ate of Maryland		irtment of F tificate of L		and M		•	001	1	25270
			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	incate or L	Jealii		2. Date of Dea	Reg. No ath	211	+	3. Time of Death
	Physicia Medic		Mary Madeleine A	dams					October	$r 21^{Da}$, 2011	ar	7:50 a.m ^M
*	Examin	er	4a. Facility Name (if not institution, give street ar	,		4b. City, Town, or	_	of Death		1	. County of D	_	
	Funeral		47539 Point Lookout 1 5. Social Security Number 6. Sex	Road 7. Age (In yrs. last	birthday)	Park Hal	If Under	r 24 Hrs.	8. Date of Birt		t.Mary		ace (State or Foreign
	Director		216 - 30-3976	X F 80	Yrs.	Months Days	Hours	Min.	10/25/) Ma	Countr ry12	y) -
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	Town or Loc	ation						10	d. Inside City Limits
	Maryla Ba-f s	Director	Maryland St. Mary's	Lexin	ngton	Park							1 Yes 2 XNo
	h the had a or 2 be no		10e. Street and Number	13011.11		10f. Zip Code				10g. Ci	tizen of What	Countr	y?
	ath wit ms 23 must	Funeral	19262 Point Lookout I	Road s Decedent Ever in U.S.	140.14	20653		1-1-0 (0	M. Mar and N.	Uni	ted St		
9	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fi	1 Never Married 2 Married 1 Arm	ned Forces? Yes 2 X No	If	/as Decedent of H Yes, specify Cuba	n, Mexica	n, Puerto R	ican, etc.)		14. Race - A Black, W		
003	tural", al Exa	ted	3 21 Widowed 4 L Divorced Yea	es, Give r or Dates.	1	☐ Yes 2 🏻 No	Specify	··			Specify: W	/hit	e
75	72 hc an "na Medic	Completed	15. Decedent's Education (Specify only highest grade comp	oleted)	(Give k	ent's Usual Occup ind of work done o NOT use retired)		at of workin	g	16b. K	(ind of Busine	ess Indu	istry
212	within 72 /giene. ner than t, the Me	ပ္ပ	Elementary/Seconday (0-12) Coll	ege (1-4 or 5+)	Iomema					Own	Home		
and	be filed ental Hy ked oth ic event	To B	17. Father's Name (First, Middle, Last)						(First, Middle,				
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ž	and 2 sh Health a tem 27 is		Christopher Adams/Son			30x 113,				, ony or 2066	_	, <i>Zip</i> 00	ide)
Baltimore, Maryland 21215-0036	t of He friten or oth		20a. Method of Disposition 1	20b. Plac	e of Dispos	sition (Name of atory or other place			ate	20c. L	ocation - City	or Tow	n, State
ţ	permit. Page 1: Department of I Important: If it any injury or of		4 Donation 5 Other (Specify)			Cemeter			/2011	Grea	at Mil	1s,	MD
Ba	permi Depar Impo any ir		21. Signature of Fyneral Service Licensee Kathleen Santivasc	i M00872		Name and Address Ho11		DLT	nsfield d, Leon	d Fu nard	neral town,	Hom MD	e, P.A. 20650
	E 24-		23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final	that caused the death. It on each line.	Do not ente	the mode of dyin	g, such as	cardiac or	respiratory arr	rest,			Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition	ue to (or as a consequen	ce of):							+	onder and Death
	Examiner	L	Sequentially list conditions, b. —	H.	11/200	16N87	NEO						45174
	sit sit	Examiner	if any leading to immediate D cause. Enter Underlying	ue to for as a conse uen	ce of:	10N /101	v	Tul	2 = = = = = = = = = = = = = = = = = = =	La d		4	MOVINS
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Box 68760	rtificat ling ph e as th	/Mec	IF FEMALE:										
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Division of Vital Records, P.O.	s the	by	Part II. Other significant conditions contributin	g to death but not resulting	ng in the ur	derlying cause giv	en in Part	1.	23e. Did to		1		cause of death?
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Re	rsician: The law rs certificate has E		05.11						perfo 1 \(\sum \) Yes	rmed?	death		
/ital	rsiciar s certif lirecto	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	1 Inpatient 2 ER	/Outpotions	Othe		th (Check o			X	(6.)	Sen'isence
of	ng Phy ter this neral c		27. Manner of Death 1 Natural 5 Pending		b. Time of injury	28c. Injury work	at		Bd. Describe h			pecity)	Residence
ion	tendir Jeath. tor: Af the fu	Certificate:	2 Accident Investigation			M 1 🗆	Yes 2 🗆	_					
ivis	or At after of Direct	Cert	4 Homicide determined 28e,	Place of Injury - At home building, etc. (Specify)	, farm, stre	et, factory, office		28	Bf. Location (S City or Tow			Rural F	Poute Number,
	Hospita Hospita Funeral	Medical	29a. Certifier 1 Certifying Physician: To 2 Medical Examiner: On the	he basis of examination an	nd/or investi	aation, in my opinio	 n. death or 	ccurred at the	he time, date a	nd place	and due to t	he caus	e(s) and manner stated.
	To the		only one) 3 Certifying Nurse Practical Control of Certifying Nurse Practical Control of Certifier Certifier Control of Certifier C	oner: To the best of my kn	nowledge, de	eath occurred at the 29c. License	time, date	and place,	and due to the	e cause(s	s) and manner te signed (Mo	r as stat	ed.
				MI		DS	6600	76				-5-	
) RI	me		30. Name and address of person who completed	cause of death (Item 23	ia) (Type, Pr	int)	OCH	TES	no	Rit	Week	>	KID
	Stat Registra	_	31. Date filed (Month, Day, Year)	32 Registrar's Signature									
			OCT 2 6 2011	Brown S.	-00	Ken							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Doris Apy 0225 tober 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Salisbury Rehabilitation & Nursing Ctr. Dicomico If Under 1 Year If Under 24 Hre 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Mir 043-05-5861 93 Director Washington Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If fire m 21 is marked other than "natural" 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1**X** Yes 2 □ No Maryland Wicomico Salisbury 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21804 USA 1700 E. Gate Drive, Apt. 608 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify Completed 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Medical Office 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Edna Wood Frank Earnest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20980 Nanticoke Rd., Bivalve, MD 21814 Katherine Martin/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 A Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 10/10/2011 Salisbury, MD Signature of Funeral Service Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Theoselestie disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence or): attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe Yes 2 No 2 No Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner?
1 Yes 2 No Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after or To the Funeral Direct 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur 29d. Date signed (Month, Day, Year, 10 5E Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signature

ammed Muktar Abduselam 11-07808 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2011 35280 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3. Time of Death Physician/ Month Day October 17, 2011 2124 hrs Medical Examiner MOHAMMED 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Prince Georges Hospital Prince George's Cheverly 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Days Hours Director 693-07-0432 37 Country) ETHIOPI 1 M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10 10a. State 10h County 10c. City, Town or Location is 23a or 28a-f show is ootified at ooce. WASHINGTON DC 1 X Yes 2 No Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho
injury or other traumatic event, the Medical Examiner must be optified at occ. Director 10e. Street and Number 10g. Citizen of What Country? 20003 1152 THIOPIA MORSE Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 2 X No Yes Specify: BLACK 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) STATION CASHIE 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname ABDUSELAM HASSEN MUKTAR VOSSILA 19a. Informant's Name/Relationship (Type, Print) COUSIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MORSE STREET WASHINGTON DC, 2000 SULEIMAN NESREDIN 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Place of Disposition (Committee of Dispositi 1 Burial 2 Cremation 3 Removal from State 10/19/2011 FREDERICK MD ALFIRDAUS MEM. Donation 5 Other Specify: 22. Name and Address of Facility A DEN MUSLIM FUNE AL 21. Signature of Funeral Service Licensee Bells ST. WOODBRIDGE EAS 23a. Part I. Enter the dil ease, or complications that caused the death. Do not enter the mole of dying, sand as cardiac or respiratory arrest, shock, or hea Physician failure. List only one cause on each line. Between Onset and /Medical Death a. Gunshot wound of chest Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physiciao: The law requires that the death certificate be executed and ician/Medical UNPENDED AMENDED the attending physician ned for use as the burial Box 68760 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o <u>۾</u> Δ. 1 Yes 2 No 3 Probably 4 V Unknown Completed Records, s certificate has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of page 2 s performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Division of Vital Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 FR/Outpatient 3 DOA 2 No After this 1 🗸 Yes 28a. Date of Injury 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Certification: Oct 17, 2011 Subject shot 2040 hrs Natural 1 ✓ Yes 2 No 5 Pending within 24 hours after death.

To the Fuoeral Director:
completely filled in by the f Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 2917 Martin Luther King Jr. Avenue SE., Washington, D 4 V Homicide (Specify) Fuel Station 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) **OGME** O.C.M.E. October 18, 2011 ale JR. Fame and address of person who completed sales of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registra Signat State are Registra

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2. Date of Death

3. Time of Death

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, ed by the al peeu has certificate or Attending Physicien: this After this funeral of

Baltimore, Maryland 21215-0036

Florence Margaret BINAU 7:53a. M October 23, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Coffman Nursing Home Hagerstown Washington If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 1 F 217 - 01 - 31 - 392 Director April 10,1919 Maryland Usual Residence of Decedent 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "neturel", or items 23e or 28e-1 show other treumetic event. The Medical Evarance must be notified at 1 TYes 2 No Directo Maryland | Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1304 Pennsylvania Avenue 21742 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No Specify: Completed by 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other treumetic event Elementary/Secondary (0-12) College (1-4or 5+) 10 0 homemaker her own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilbur Marion Moberly 2 Mary Margaret Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice McNamee - daughter 207 Sunbrook Lane, Hagerstown, Maryland 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State October 24, 2011 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory Hagerstown, Maryland `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home hobert B Va 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** PALLUNG TO THRIVE Wases disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SMGE DEMENTUA LAN 13 1 cmu MUDANCED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Yemy Comercie Obstructive LUMA DISENSE that initiated events resulting in death) Last Due to (or as a consequence of): Y GMM -Physician/Medical HURCHYBYSION 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by of Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 KiUnknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 PNo 24a Was an autopsy performed? Yes 2 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 4 Y Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 🗷 Natural Injury 1 ☐ Yes 2 ☐ No d in by the f 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospitel o within 24 hours aft To the Funerel Di Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D46561 Oct, 24, 2011 MD caw completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 3 1190 M ROAD HAGEGROWN MO 21740 AUMA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 25 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 **Physician** p^{M} 5:13 Frederick William Burton October /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ellicott City Howard Lighthouse Assisted Living If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05/15/1929 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1**⊠**M 2□ F 82 CT Director 046-22-3326 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 TNo Elkridge Directo Howard MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21075 6013 Duckeys Run Road items 23a United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 24 Yes 2 □ No 1947-13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 □ Never Married 2 □ Married 'natural", or 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White þ 3 Widowed 4 N Divorced 1950 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Aircraft Procurement Officer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and Mental Fis marked ot Lois Frances Slason Charles Raymond Burton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is 0 Ellicott City, MD 21043 4537 Rusty Gate Victoria Hathaway - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 10/24/2011 injury (Ardent Crematory Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Dicensee inde 4112 Old Columbia Pike Ellicott City, MD 21043 m 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Alzheimer's Dementia disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 10 No 1 ☐ Yes 2 No 1 TYes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) by 4 Homicide 24 hours 🛮 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 24, 2011 D47447 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 34 21044 Lazris. Suite 103 Columbia, MD 6334 Cedar Lane Andrew -MD 31. Date filed (Month Year 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Grace Romaine Siegman Buschman October 2:30 p 2017 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Golden Crest Assisted Living Hampstead If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 917 219-07-2515 1 M 2 X F Days Oct 12, Director 94 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Maryland Carroll Hampstead 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4019 Evergreen Avenue 21074 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🗶 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", white Completed 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Factory Seamstress Be with and Mental Ha 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Clayton Monroe Siegman Ruth Virginia Shaeffer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Kenneth R. Siegman, brother 1616 Manchester Road, Westminster, MD 21157 tem 20a. Method of Disposition 20b. Place of Disposition (Managers) cemetery, crematery of time place) St Benjamin's 20c. Location - City or Town, State permit. Page 1 a Department of I-Important: If ite any injury or ot Date 1 Burial 2 Cremation 3 Removal from State 10/18/2011 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral 91 Willis Street, Westminster, MD 21157 100 23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause are each line. Approximate Interval Between Onset and Death Physician/ disease or condition resulting in death) DIDNOR Medical Due to (or as a consequer ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examir or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial physician the burial Physician/Medical Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year the 9 Uriknown 9 Unknown Division of Vital Records, P.O. as been signed by 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha performed' 1 Yes 2 No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 4 Nursing Home 5 Residence 6 Nother Special Living 1 Yes Other: ပ္ this c 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death nours after death.

neral Director: After the filled in by the funeral Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) WJL

Registrar DHMH 17 Rev 7/2009

State

114 Business

Ctr

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Vento

d.h

32. Registrar's Signature

Thomas

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ernest Lee Bratten 20% Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisbur toninoula Regional medical cente Wiconico If Under 24 Hrs 8 Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Min (Month, Day, Year) Days 219-82-9355 1 🖾 M 2 🗆 F **Director** 1-4-1961 MD 50 show 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 28a-f 1 Yes 2 X No MD Worcester Girdletree 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a USA 21829 6653 Box Iron Road death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 XNever Married 2 Married Baltimore, Maryland 21215-0036 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. SpecifyBlack "natural", Completed 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 Ag Chemical Co. Laborer of Health and Mental Hygi item 27 is marked othe other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ |Helen Gillette Ernest L. Bratten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Helen Gillette/Mother 6653 Box Iron Rd, Girdletree, MD 21829 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burlai 2 Cremation 3 Removal from State cemetery, crematory or other place, 10-8-2011 4 ☐ Donation 3 ☐ Other (Specify) Spring Cem |Girdletree, MD Bennie and Address of Facility 917 W. Isabella St. 21. Signatu Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to for es a consecuence offi cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last for use as the burial-transi Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Onknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year,

State Registrar FERN STORE DR. SALISBURY MDZ (804

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Amend#23b.PenPhys.PGC10-20-11cr Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 4. Day 2011 Year 1600 Kevin Charles Ford Bey Sr. 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (Mopth, Day, Yea April 28, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 № M 2 🗆 F Months Hours Min ^{ear)} 1956 Yrs DC 577-74-4248 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Washington DC 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20019 5542 B Street SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b Kind of Business Industry life. DO NOT use retired) College (1-4 or 5+) Private Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles E. Ford Sylvia Chase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Washington, DC 20019 5542 B Street SE Janice Ford - Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, October 0 4 Donation 5 Other (Specify) Washington, DC **Glenwood** 2011 22. Name and Address of Facility Stewart Funeral Home, Inc. Signature of Funeral Service Licensee to king 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 ☐ Yes 2 🔀 No Yes 2 X No

Physician/ Medical Examiner

Exami

Physician/Medical

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Completed

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Certificate:

Medical

29a. Certifie

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only one) 29b. Signature and titl

other

Department of H Important: If ite any injury or ot once.

permit.

Physician/

Medical

Director

Funeral

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Completed

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Examiner

Funeral

Director

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ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at

Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items

Baltimore, Maryland 21215-0036

with the Maryland

the burial-tran and attending physician for use as the burial pau the signed by the been cate has page 2 s After this certificate funeral director, death. nours after death.

neral Director: A

filled in by the fu

Hospital or Attending Physician: The law requires that the death certificate be

Box 68760

P.O. I

Division of Vital Records,

23b. Was decedent pregnant Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗶 No 1 Tyes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident work 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

within 24 ho

To the Fune State Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Omolola O. Adesina, MD 3001 Hospital Drive Cheverly, Maryland

31. Date filed (Month, Day, Year)

OCT 2 0 2011 Registrar

24 hours a

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35286 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month)ctober Helen Jean Bond 1055 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wicomico teninsula Regional Medical Conter Salisbur If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, Year) Hours 214-34-2373 Director 74 1 🗆 M 2 🕱 F Nov. 28, 1936 Maryland Usual Residence of Decedent 28a-f show 10c. City. Town or Location Director 10d. Inside City Limits Maryland Wicomico Parsonsburg 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 21849 USA 7473 Madeline Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ an "natural", or Medical Examir 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than " Elementary/Secondary (0-12) College (1-4 or 5+) alth and Mental Hygien 27 is marked other to r traumatic event, the 9th Homemaker domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frances Margaret Poffenverger George Wilhelm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn A. Bond, Sr./son Health em 27 11037 Hopewell Road - Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 5 Department of Important: If any injury or once. Salisbury Crematory 10/10/2011 Salisbury, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility 1213 Jersey Road, Salisbury, MD JOLLEY MEMORIAL CHAPEL 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Adenocalicinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 as the IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Day 1 Yes 2 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CAD HTN Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 X N certificate 2 No 1 🗌 Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 1 💢 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖄 Natural work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Aminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated triying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date/signed (Month, Day, Year) H54827 s of person who completed cause of death (Item 23a) (Type, Print) BLYBULATER PLEATE PLE SUITE WIS SAUSBULY LID ZIENY MAN

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month OCT. PATRICIA BORTLE \mathbf{P}^{M} Α. 2011 1:41 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WORCESTER 12360 POINT VIEW ROAD BISHOPVILLE Social Security Number 7. Age (In yrs, last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Year Funeral 1 🗆 M 2 🛛 F Months Hours Min. (Month, Day, Year, MARYLAND **Director** 217-40-4913 68 FFR 1943 Usual Residence of Decedent show 10a. State 10b. County with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2X No MARYLAND WORCESTER BISHOPVILLE 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? items 23a Funeral 12360 POINT VIEW ROAD 21813 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 'natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: WHITE 3 X Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ADMINISTRATIVE ASSISTANT 12 INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 LAWRENCE AKERS MILDRED ZYBELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY V. WOOLFORD/NIECE LINGANORE CT., WESTMINSTER, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARVA 4 Donation 5 Other (Specify) 10/12/11 DELMAR, DELAWARE 21. Sign Jura 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the deshock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Onset and Death Pnysician/ nortus disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectonic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant Unknown Dav Year Pregnant at time of death 5 Other (specify) by the a 9 Unknown signed by ti d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an cate has autopsy performed? Yes 2 2 No this certificate Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 ☐ Yes 2 No မှ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 🛮 Natural iniury 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide determined City or Town, State) Medical Z Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

State

376

ighthouse Road Selbyville Delaure 1997

Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

A	MEND IT	EM	31 WCHD/TF 10/24/	Type or Print in	Black	Indelible Inl	k. Ens	sure All	Copies A	re Leg	ible.	
		-	For State PER HD	State of Marylar	id / Dep	partment of F ertificate of L	Caltil	and Mer	itai i iygie		1 1	35288
			Registrar 1. Decedent's Name (First, Middle, La.	st)		Timoate of L	Jeann	2.	Reg. Date of Death	Ng2 ()		3. Time of Death
н	Physicia Medi		KENNETH GE	RALD CRI	PPE	\sim		Oc.	Month Tober	Day 2	Year	03:07 PM
, All.	Examir		4a. Facility Name (if not institution, give		n me	4b. City, Town, or	Location (-		4c. County	of Death	
425	Funeral		5. Social Security Number 6. S			If Under 1 Year	If Under	24 Hrs. 8	Date of Birth		9. Birtl	hplace (State or Foreign
	Director		213-22-3615 Usual Residence of Decedent	X M 2 □ F 84	Yrs.	Months Days	Hours	Min. 12	Month, Day, Yea	ar)		nois
	yland f sho	tor	10a. State 10b. County	10c. Cit	y, Town or L	ocation						10d. Inside City Limits
	Jeath with the Maryland Items 23a or 28a-f show Ier must be notified at	Funeral Director	MD Washing 10e. Street and Number	gton H	agerst	Own 10f, Zip Code			1.40	0:::	1/h - 1 C - 1	1 Yes 2 No
	with th	eral	10116 Sharpsburg	Pike		217	40		109	Citizen of \		and y?
	leath \	Fun	11. Marital Status	12 Was Decedent Ever in III	S. 13	Was Decedent of H		igin? (Specify	Yes or No-	14. Rac	e - Amer	ican Indian,
36	filed within 72 hours after death with the Maryland al Hygiene. 1 other than "natural", or items 23a or 28a-f sho vent, the Medical Examiner must be notified at	þ	1 Never Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give		1 ☐ Yes 2 X No			n, etc.)	Specify.	k, White	, etc.
Maryland 21215-0036	ours a atural cal Ex	Completed	3 Widowed 4 ☐ Divorced 15. Decedent's E	Year or Dates.	16a Dec	edent's Usual Occup			161		Whi	
215	s filed within 72 hour tal Hygiene. ed other than "natu event, the Medical	ldm	(Specify only highest gr Elementary/Secondary (0-12)		(Giv	e kind of work done of DO NOT use retired)	during mos	st of working		o. Kind of B		
21	iled withii I Hygiene other th		Elementary/Secondary (0-12)	2	Dr	iver			T	'ransp	orta	tion
and	e filed ntal Hy ed oth even	To Be	17. Father's Name (First, Middle, Last)						st, Middle, Maid	len Surname	e)	
N N	ould b of Mer mark matic		James Crippen 19a. Informant's Name/Relationship (7)	!	10h M-1	line Addunce (Otroch	Rul			Ta (toto Zin	Co.d=1
	12 sho alth an 27 is r trau	1	Sharon Lacy / Day		1	ling Address (Street a						
re,	1 and of Hea Fitem		20a. Method of Disposition	20b. F	Place of Disp	position (Name of ematory or other place		Date		c. Location		
Baltimore,	permit. Page 1 and 2 should be filed Department of Health and Merital H Important: If item 27 is marked otl any injury or other traumatic even once.		1 ■ Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.	Henloval Holli State		y Gap Cem	· .	7 10/25	/11 F1	intst	one,	Maryland
3alt	permit, Depart Import any inj once.		21. Signature of Funeral Service Licen			22. Name and Addres	ss of Facili	ty Rest	Haven	Funer	al C	hape1
	<u> </u>	\dashv	23a. Part 1. Enter the disease, or com	plication, that caused the deat		601 Penns				rstow	n, M	
П	District of		shock, or heart failure. List only o	ne caust on each line.	0	iter the mode of dylin	g, such as	cardiac or res	piratory arrest,			Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Pull Mo							- 4	
-	Examiner	,	Commented to the state of the s	Ashirati	on							iodays
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376	ficate g physas the	Medi		d								
Box 68760	ending r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnanc	:v			23d. Da	te of deli	very
	res that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit	Completed by Physician/Medica	in the past 12 months? 1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of a 9 ☐ Unknown		Other (specify)	,			Mo	nth	Day Year
P.O.	at the	F.	Part II. Other significant conditions c	ontributing to death but not res	ulting in the	underlying cause giv	ven in Part	1.	23e. Did tobac	co use cont	ribute to	the cause of death?
	ires the signer of signer	d b	Alzheimer's	Demontso	1				1 🗆 Yes	2 🗌 No	3 🗆 Pr	obably 4 Unknown
ord	w requires s been sig) Set							24a. Was an	24b. ¹	Were aut	opsy findings available
3ec	The lay	mo							autopsy performed	No.	death?	ompletion of cause of
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Division of Vital Records,	Physic this or	은	1 Yes 2 No	Hospital:			4 🗌 N	1	5 Residence			fy)
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isio	Atten ector: by the	ij.	3 Suicide 6 Could not b	e 28e. Place of Injury - At ho			100 2 2	28f.	Location (Street	and Numb	er or Run	al Route Number,
Ď	tal or rs afte al Dir led in	ပ္ကို		building, etc. (Specify	")				City or Town, St	ate)		
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Medical Certificate:	(Check 2 \(\sum \) Medical Exam	sician: To the best of my know ner: On the basis of examination	n and/or inve	stigation, in my opinic	on, death o	ccurred at the t	ime, date and pl	ace, and du	e to the c	ause(s) and manner stated.
	o the vithin or the comple		only one) 3 ☐ Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the best of r	ny knowledg	e, death occurred at t 29c. License		ate and place, a		Date signer		
			> Hnu Ves,	NO MBE	55	RES	00	00	0	ctob	Cr	19 2011
	XX.		30. Name and address of person who	completed cause of death (Item	23a) (Type,	Print)	0.4		001-02	1901	W.B	17 2011 RELVEDEREME REND-21218
	10		ANU VERMA	, SINAI HO	SPIT	AL OF	B46	11M	UKS 1	BALT	110	REND-21215
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	2011	Marina	A	back	-			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#23aperMDir; 10/31/11; BMV, Moco Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 17, 3:49 2011 Shirlee Η. Craig October /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Silver Spring Montgomery Arcola Health & Rehab. Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 28 F 578-38-3004 D.C. 84 Director June 5, Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show if than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Director MD Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20902 USA 1111 University Blvd., West, #1502 death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: filed within 72 hours after Specify Black 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 2 No Specify. ð 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Teacher Education [] ith and Mental Hygie 27 is marked other if traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Booker T. Hunt Gertrude Ward ဨ 20902 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trainonce. 1111 University Blvd. W., #1502, Silver Spring, MD Walter Craig/Husband Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Oct. 26 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, VA 4 ☐ Donation 2011 21. Signatury of Funeral Service Live 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 Approximate Interval Between Onset and Death 23a. Part is inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Pulmonary Embolism Immediate Cause (Final disease or condition resulting in death) Anoxic days **Physician** 12 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dire to (or as a consequence of) if any, leaving to immade cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the HospItal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transal. sician and buriantian Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐No 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner eath 1 Tatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Division of Vital Records, completely

00064624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sunner Will Dr. Catherstor, MD 20878 SHIMMA SANDEER 743

and manner stated.

State Registrar

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Medical

29a. Certifier

(Check only

29b. Signature and title of certifier

31. Date filed (Month, Day, 32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

3. Time of Death

10d. Inside City Limits

20010 Approximate Interval Between Onset and Death

Year

29d. Date signed (Month, Day, Year)

10-12-11

1 Yes 2 No

2:55 pm M

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Dpinder Singh, MD

2 1 201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D45660

14300 Gallant Fox Lane Ste 124 Bowie, Md. 20715

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 18, 201^{Year} 6:03 p^M Rossi L. Cofield Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min Aug. 26, 1 X M 2 - F Months "NC 238-64-9276 Yrs **Director** 69 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits with the Maryland 10c. City, Town or Location **Funeral Director** notified 28a-f 1 Yes 2K No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or 14620 Cutstone Way 20905 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates. 1962–65 SpecBlack Completed 3 Widowed 4 Divorced 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Store Manager Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mable Cofield Bertha Pittman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eva M. Cofield/Wife 14620 Cutstone Way, Silver Spring, MD 20905 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 CxCremation 3 Removal from State cemetery, crematory or other place) Oct. 25 Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA 21. Signature of Funeral Service License Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring. MD 20901 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Immediate Cause (Final Onset and Death Physician/ Cardiac Arrest disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Valvular Heart Disease Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and that initiated events resulting in death) Last for use as the burial-tra Due to (or as a consequence of): signed by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
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1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? cate has autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ပ 1 🗌 Inpatient 2 🍱 ER/Outpatient 3 🗌 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause

Farzad Malekanian, MD 1500 Forest Glen Road, Silver Spring, MD 20910 32 Registrar's Signature

of death (Item 23a) (Type, Print)

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10/19/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 35292 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Freeman Norris Childers 2011 Oct. 1646 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Hospital Prince Georges Cheverly 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Hours Min **Director** 248-38-4760 1 XM 2 □ F 85 4/8/1926 SC Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location Examiner must be notified at Director 1X Yes 2 ☐ No DC None Washington 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 4347 16th Street NE 20017 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Ukn 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black White, etc. δ 1X Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify Completed 3 Widowed 4 Divorced Black Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12th Police Officer DC Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental H Henry Dutton Childers Cynthia Whisonant 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4301 Bowling Brooke Court Kathy Cherry/Daughter or other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit, Page 1: Department of I Important: If its any injury or of 1 X Burial 2 Cremation 3 Removal from State Ft. 10/21/11 Brentwood, MD Lincoln 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latney's Funeral Home, Inc. 21. Signature of Funeral Service Licensee cc0278 3831 Georgia Ave. NW Washington, DC 20011 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) FATAL CARSTAC Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the bun Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Pregnant at time of death been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 100 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has le 2 perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 Other: 1 Yes ည 1 Inpatient 2 PR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? within 24 hours after death.

To the Funeral Director: After t Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of pty knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year. 150/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHEVERLY, MD 20785 3001 HOSPITAL DRIVE SATTARIAN NEDIT MD 31. Date filed (Month, Day, Ye 32. Registrar's Signature State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month / O Physician/ 07.59 M Preston Elwood Campbell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 579222157 1 🛣 M 2 🗆 F Country) Virginia 1918 Nov. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 No Ocean Pines MD Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21811 5 Bramblewood Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 ☑ Yes 2 ☐ No 1943—
If Yes, Give
Year or Dates. 1945 1 Never Married 2 X Married 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) service station owner & operator 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mamie Ernestine Sandford John Robert Campbell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvonne M. Campbell (Wife) Bramblewood Drive Ocean Pines, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Delmar, Delaware Crematory of Delmarva 10-8-2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street 19940 Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and eath Immediate Cause (Final Mayocardial disease or condition resulting in death) minus Due to (or as a consequence of): Hypertensor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a onsequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death
☐ Unknown 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▶ No 24a. Was an autopsy performed? Yes 2 Mo hyperlifedomia as case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 힏 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 Yes 2 No Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation

Examiner P.O. **Division of Vital**

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ermit. Fage 1 and 2 should be filed wit Departm nt of Health and Mental Hygie Important: If item 27 is marked other ny injur or other traumatic event, tt noe.

Physician/

Medical

Examiner must be notified at

5,10

Medical

(Check only one)

29b. Signature and title of certifier

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Do05225)

Dr. Cambridge, HD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar's Signatur

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State of Waryand 7 state of Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $\underline{10}^{\mathsf{Day}}$ Month Physician/ 1950 P ^M Hilda Marie Canton 10 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 9. Birthplace (State or Foreign US Country) St. Croix 9 Virgin Islands If Under 1 Year If Under 24 Hrs. 8, Date of Birth Funeral 7. Age (In vrs. last birthday) Days (Month, Day, April 1 Hours 1 M 2 F **Director** 095-26-7511 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location the Medical Examiner must be notified at Director 1 Yes 2 No Hyattsville Prince George's MD 10f. Zip Code 10g. Citizen of What Country? 6 10e. Street and Number items 23a Funeral 20783 United States 6500 Riggs Road death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. o, 1 Yes 2 No
If Yes, Give
Year or Dates. 2 1 Never Married 2 Married Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify. **Black** "natural" 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Hotel Maid 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna E. Daniel other traumatic William Canton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9008 Cooper Drive, Fort Washington, MD 20744 Marva L. Bigelow/Daughter Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) injury or 1 X Burial 2 Cremation 3 X Removal from State 10/22/2011 ST.CROIX.VIRGIN ISLANDS 4 Donation 5 Other (Specify) KING HILL CEMETERY 21. Signatur Parrial Service Lie 22. Name and Address of Facility any i 5538 Marlboro Pike, Forestville, MD 20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year 5 Other (specify) Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Unresectable 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed? Yes 2 No death? certificate l Sairun 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 █ No filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: မှ r ☑ mpatient 2 💢 ER/Outpatient 3 🗆 DCA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifie 86 010 address of person who completed cause of death (Item 23a) (Type, Print) Date filed (Month, Day, Year) (

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Sign Rure

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registrar Amend#23apart_1_25_PerMEPCC10-24-11c6ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 6, Day 2011 Year 00:30 A M Daisy A. Cureton Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country)
 DC 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🏝 F Days Hours Aug. 23, Months Min ^{Yea}[1930 Yrs **Director** 81 578-52-0709 Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 X Yes 2 No Clinton Prince George's Maryland Ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20735 8600 Mike Shapiro Drive # 314 death 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify 3 Widowed 4 A Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r United States life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Office 12th Sorter Post injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice Henderson Joseph Durham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5136 St. Aubin Drive Taledo, OH 43615 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Phillip R. Pettaway - Grandson Baltimore, 20a. Method of Disposition October 11, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗷 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Landover, Maryland Harmony 2011 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ "SCUS disease or condition Medical resulting in death) Due to (or w a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and -trans Duodenal Ulceration in the Small Intestine Due to (or as a consequence of) nding physician al use as the burial-t Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) atter in the past 12 months?

1 Yes 2 No for Pregnant at time of death Month Day Year the P.O. signed by to d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s Jas performed? Yes 2 N this certificate 2 No 1 Yes Division of Vital funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ြုင 1 XYes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at After 1 Natural 5 Pending Accident work?
1 Yes death. 2 🗌 No Investigation 24 hours after deat Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

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completed fi (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 07285 s of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 16, 201 a Crawford 10:09 AM Mary Elizabeth Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Community Hospital Cheverly Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Hours (Month, Day, Year) Days Director 578-36-6513 1 □ M 2**X** F 82 Virginia Oct. 25, 1928 Usual Residence of Decede 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director D.C. Washington 1 X Yes 2 □ No ms 23a or r must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1814 Newton Street, N.E. 20018 U.S. death items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò þ 1 Never Married 2 Married Yes 2 XNo African-American altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural" Completed 3X Widowed 4 □ Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Food Service Dietician 12 of Health and Mental Hygitem 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Annie Coleman Rodger Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Melinda Crawford-Daughter 3938 C Street, S.E., Washington, D.C. 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-28-2011 Brentwood, MD Lincoln Cemetery Funeral Service License 22. Name and Address of Facility Bonnette & Assoc. Funeral Home 2504 28th Street, N.E., WDC 20018 Signature 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ erminal disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). use as the burial-transit and Due to (or as a consequence of): attending physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X No completely filled in by the funeral director, page 2 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signat (L28 (Type, Print) 30. Name and address of person who completed cause of death (#6)

State Registrar 31. Date filed (Month, Day

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35297 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 11, 2011 Robert Milton Caldwell 9:35 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Salisbury Wicomico 1014 Evergreen Ave. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days **Director** 217-36-1341 1 **X**M 2 □ F 01/31/1941 Maryland 70 rtant: If item 27 is man led other than "natura", or items 23a or 28a-f show njury or other traumati event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1014 Evergreen Ave. 21801 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 IX Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Real Estate Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) it. Page 1 and 2 should e file rtment of Health and Mr ntal I rtant. If item 27 is man ed o James H. Caldwell Dorothy Houston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1014 Evergreen Ave., Salisbury, MD 21801 Madalene E. Caldwell/Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 10/13/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) enature of Foneral Service Licensee 22. Name and Address of Facility Holloway Funeral Home Professional Association Dep Com 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Metostatic Adenocurcinona et Lun disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami that the death certificate be executed ending physician and use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? certificate 1 Yes Yes To the Ho pital or Attending Physician: Twithin 24 hours after death.

To the Fur eral Director: After this certifies director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 You Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of Certificate: 28d. Describe how injury occurred 1 Matural injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

— Gordfying Number Practition and the state of the first of the cause of the ca (Check 29b. Signature and title of certifier 29c. License number 730690 Oct. 12,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Groll St., Selisburg, MD 21801 Dones MARTIN M.D. E.

DHMH 17 Rev 06-2011

Registrar

31. Date filed (Month, Day, Year

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of Vital

Division

Registrar's Signature

State of Maryland / Department of Health and Mental Hygien Certificate of Death Registrar Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Coates 2011 9:50 October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 8697 Northumberland Drive Delmar Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Hours 267-78-6863 Director 1 X M 2 D F 65 08/17/1946 Florida 28a-f shov an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 ☐ Yes 2X No Wicomico Delmar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8697 Northumberland Drive 21875 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 XNo Specify. White Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injug, or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Carpenter Carpentry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cleo Patrick Poe Charles Robert Randolph 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8697 Northumberland Dr., Delmar, MD 21875 Martha J. Coates/Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🛭 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory Salisbury, MD 10/11/2011 Si mature of Fund Licensee Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one ca etastatic A Immediate Cause (Final Onset and Death Physician/ denocarcinoma & Un Known disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Samuer fields list elections if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate completely filled in by the funeral director, pag 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work' 2 Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be filled in by the Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature ar title of certifier 29d. Date signed (Month, Day, Year) 0 of person who completed cause of death (Item 23a) (Type, Print) 21801 λ 1ZQ 100 31. Date filed (Month, Day, Year) State 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32.

State of Maryland / Department of Health and Mental Hygin for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ oct. Day 201 T ₿:57P 12, J. Dixon Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Charles 12741 Pearson Drive Apt. Waldorf 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav **Funeral** Country) NY 1 □ M 2 🗓 F Days Hours Min 3 Man 9 Par 9 24 3 68 Director 081-34-1385 Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 □ No Waldorf MD Charles 10f. Zlp Code 10e. Street and Numbe 10g. Citizen of What Country? ul Hygiene. I other than "natural", or items 23a or vent, the Medical Examiner must be I Funeral USA 20602 12741 Pearson Drive Apt. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 № Never Married 2 ☐ Married þ within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Government Social Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked o permit. Page 1 and 2 should be 1 Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ew once. မှ Henry O'Bryant Pauline Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53rd. St. Philadelphia, Pa 19143 1047 S. Venus Rogers/Daughter altimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 10/26/11 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake 22. Name and Address of Facility Latney's Funeral Home 21. Signature of Funeral Service Licensee 3831 Georgia Ave. NW Washington DC20011 cc0278 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 0 OV disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of). attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Year the 9 Unknown P.O. signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law has autopsy performe within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 မ ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗓 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin Krishah State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Month Physician/ 8:20 A 10 Juanita Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital <u>Takoma Park</u> Montgarery 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral Days 1 □ M 2 😾 F Hours Min Country) 11//12/1933 Director 238-50-8050 NC 77 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. I them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1X Yes 2 No Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 20782 USA 3621 Gallatin Street 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Hospital Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edna Mae Hargrave permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Cleveland Giles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5025 37th Ave Hyattsville, MD 20782 Billy D. Davis Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 10/18/2011 Chesapeake Crematory Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Philip D. Rinaldi Funeral Svc., PA Signature of Funeral Service Licensee 9241 Columbia Blvd. Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Longestive Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burdel transit. Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
g Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No 1 ☐ Yes 2 🍒 9 ☐ Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed⁴ 1 ☐ Yes 2 ☐ No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🖳 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in rily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00060100 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Silvesing more BLUD Sant Iniversity

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

OCT & U 2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend Item 5 per FH G921 11/8/11 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 35302 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 06 2011 Sylvia T. Disharoon 2139 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1400 Robins Ave. Wicomico Salisbury If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Director 217-30-9461 1 M 2 X F 09 | 23 | 1933 Maryland 78 Usual Residence of Dece 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified Maryland Wicomico Salisbury 1 Tes 2 No 10e. Street and Numbe 0 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be r 1400 Robins Ave. 21804 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Force or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced Year or Dates er than "natura the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) alth and Mental Hygiene.
27 is marked other than r traumatic event, the Mo College (1-4 or 5+) Teacher Wicomico County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Lacey Taylor Margaret Jarvis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Franklin Disharoon|husband 1400 Robins Ave., Salisbury, Maryland 21804 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ₽ <u>=</u> ö 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Department of Important: If any injury or 10/11/2011 Parsons Cemetery 4 Donation 5 Other (Specify) Salisbury, Maryland 21. Signature of Fuperal Service Licensee 22. Name and Address of Facility Holloway Funeral Home P.A. 501 Snow Hill Rd., Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph_sician/ Failure ongestive Heart Medical Examiner tension Sequentially list conditions if any, I sain to immediate cause. Enter Underlying Examiner been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 265 muchive Pulmorary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 s Director: After this certificate has autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No after death. 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 To the ! Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) hygician H5279 11 ddress of person who completed cause of death (Item 23a) (Type, Print) 1820 Sweet Bay Drive , Suite 101 Salisbury, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 0545 Wilson M. Dennis Soil Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Wicomico lisbury Rehabilitation of Nursing Ctr Dalisbu 6. Sex 1 XM 2 □ F If Under Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Days (Mor Months Min. Day, nth, Director 220-32-8920 9 MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 106 Broadway Street 21726 Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 No Yes, Give **Air** Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Force Spe Bylack 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Forklift Operator aborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ John Matthews Lucy Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 <u>Dorothy Haywood/Friend</u> Broadway St, Fruitland, MD21826 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Nurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Spring Hill Gard 10-8-2011 Hebron, MD S enturing Fund Prince Lice 22. Name and Address of Facility 917 W. Isabella St. Bennie Smith Salisbury. Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Alheoscheoti Cardio vosa to disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine any, leading to immedia cause. Enter Underlying Cause (Disease or linjury Due to (or as a surrequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? [≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy perform death? репоrmed? Yes 2 A 2 🗌 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print), TC Salis bur DIVA State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month GODON AM 1130 DISHAROON STANVILLE 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ICOMICO REGIONAL If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min 1 M 2 F Director &6 MD28a-f show 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Widomico QUANTICO 10f. Zip Code 10g. Citizen of What Country? 21856 12. Was Decedent Ever in U.S Armed Forces? 1% Yes 2 \(\subseteq \text{No} \) If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Baltimore, Maryland 21215-0036 1 Yes 2 KNo Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. AR PENTER Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maid permit. Page 1 and 2 should be Department of Health and Men Important. If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, 20b. Place of Disposition (Name of Date 1 Burial 2 Cremation 3 Removal from State Alsbury, MD 21801 4 Donation 5 Other (Specify) Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final nset and Death Physician/ Meumonia disease or condition Medical resulting in death) Due to (r as a consequence of): Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury Que to for sels consociaries on The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical Box 68760 the as IF FEMALE for use a 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav ed by the a detached f Unknown 9 Unknown P.O. signed by det 23e. Did tobacco use contribute to the cause of death? þ Records, Urinary 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an lung mass page 2 s autopsy performed 1 Yes of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 Yes Other 2 No 은 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this the funeral 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Division death. 1 Yes 2 No Accident Investigation after death Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a

To the Funeral C

completely filled To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) D9085 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harles B Silvia Regional Medica 31. Date filed (Month, Day, Year) Registrar's Signature State 2 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2011 12:53 p M Richard Tanner Ellis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard <u>Encore at Turf Valley</u> If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Mir **Director** 072-18-4714
Usual Residence of Dece 1**X** M 2 □ F 89 NY 05/30/1922 fshow ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🕱 No Carroll Sykesville MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21784 United States 631 Buckhorn Road permit. Page 1 and 2 should be filed within 72 hours after death bepartment of Heath and Mental Hygiene.
Important: If item 27 is marked when Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Army 1 Yes 2X No Specify. Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Johns Hopkins APL Electrical Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frances E. Conneely Richard Tanner Ellis, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denis A. Ellis - son 631 Buckhorn Road Sykesville, MD 21784 20a. Method of Disposition

Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 10/27/2011 Clarksville, MD 4 ☐ Donation 5 ☐ Other (Specify) St. Louis Cemetery Signature of Funeral Service Lic ns e 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician nonth disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be P.O. Box 68760 as the l 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? Day Month Year signed by the aid be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires to 24 hours after death.
 Funeral Director: After this certificate has been sign Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 45515726 Hospital: 2 410 Other: LIVING 1 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Other (Specify completely filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Suple MO 00053150

Registrar
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Santicp ad

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MO

2045

Suite

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	-	Registrar 1. Decedent's Name (First, Middle,	l act)		Cer	tificate of I	Death	100 10	Reg. No.		3530		
Physicia Medic		MARSHA	н.	LLINGS			2. Date of De Month	Day 15	Year	3. Time of Death			
Examin		4a. Facility Name (if not institution, g		,		4b. City, Town, c				ty of Death			
Eunaval		Peninsula Pegiona 5. Social Security Number	1 madical 5. Sex 7.	Age (In yrs. la	ast birthday)	If Under 1 Year	alis If Under 2				nico place (State or Foreign		
Funeral Director		221-38-7727	1 □ M 2 🛣 F	58		Months Days	Hours	Min. (Month, Da	ay, Year)	Coun			
, MC		Usual Residence of Decedent						DAN. II	33,77				
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10a. State 10b. County MARYLAND WICO	MICO	10c. City	y, Town or Lo	NSBURG					10d. Inside City Limits 1 ☐ Yes 2X No		
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ge 1 an t of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	3 ☐ Removal from St	ate c	emetery, cren	sition (Name of natory or other pla		Date	20c. Location				
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Physician/		23a. P 4 I Enter the disease, or complications that cause 1 III. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death											
Medical Examiner		resulting in death)	a. Due to (or	as a consequ	ience of):	- V -							
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To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Example)	aminer: On the basis	of examination	and/or invest	igation, in my opini	on, death occ		and place, and d	ue to the ca	use(s) and manner stated		
o the		only one) 3 ☐ Certifying N 29b. Signature appl title of certifier	lurse Practitioner: To	the best of m	ny knowledge,	death occurred at 29c. Licens		e and place, and due to	the cause(s) and 29d. Date sign		•		
. , , ,		· MAMA	MAN	1	MD	DA	1051	5	10/15	111			
STE		30. Name and address of person when the state of the stat	no completed cause of	of death (Item	23a) (Type, P	rint)	-0.0	EDA, S	ALICA	10111	1D 2/8KI		
Stat	e	31. Date filed (Month, Day, Year)	32 Regi	strar's Signat	U EM	SICHN	5/1///	- L 116/2	17612156	ILY UV	12004		
Registra	ır	OCT 18 2	1017 Cha	m f	1. Ask	Ma							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35307 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:30 am Roger J. Folstrom October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Montgomery 1816 Cullen Drive Social Security Number Year If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 8 Date of Birth Age (In yrs. last birthday) **Funeral** 1 🕱 M 2 🗆 F Months Days Yrs North Dakota **Director** 501-26-1034 Usual Residence of Decedent 28a-f shov with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a U.S.A. 20905 1816 Cullen Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14, Race - American Indian Armed Forces?
1 🔀 Yes 2 🗆 No 1956-Black, White, etc. ò þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 'natural", Specify: Completed 3 Widowed 4 Divorced 1964 white. Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
7 is marked other than "1" College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Professor of Music University injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ LaVerne Katherine Madigan James Lloyd Folstrom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 1816 Cullen Dr., Silver Spring, Maryland 20905 Jeanne C. Folstrom - Spouse 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 06 10/22/2011 Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gate Heaven Cem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home. 1232 11800 New Hampshire Ave., Silver Spring, MD 20904 med auc Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Examiner Myelosibrosis Sequentially list conditions, Examiner if any, leading to mini solute cause. Enter Underlying Cause (Disease or iinjury that initiated events that the death certificate be executed Pneumonia Due to (or as a consequence of) resulting in death) Last the burial attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? 2 🗌 No 2 **X** N Yes To the Hospital or Attending Physician: 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 💆 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death within 24 hours after death.

To the Funeral Director: After tompleted fillow in a second of the sec 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work? Accident 2 🗌 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Medical

29a. Certifier (Check

29b. Signatu

Frederick David Min. 31. Date filed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2101 Medical Park Dr., #200, Silver Spring, M.D.,

1 🛭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

D0068686

29d. Date signed (Month, Day, Year)

MD 20902

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 5, per fh, 9921 11-14-11 sm. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35308 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Helen Pollack Fink 1:35 P 2011 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Spring House Group Home Bethesda 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🛛 F Months Hours (Month, Day, 98 BrookIvn, Yrs **Director** Mar Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director notified 28a-f Montgomery Bethesda 1 Yes 2 X No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ᆼ ms 23a or must be r Funeral 20814 USA 4925 Battery Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) i "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Force Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: Caucasian Completed 3 X Widowed 4 □ Divorced the Medical 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Public Library 12 Librarian ed other event, th Be Department of Health and Mental Hy Important: If item 27 is marked off any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rebecca Minsky Samuel Pollack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4514 Dorset Avenue, Chevy Chase, MD 20815 Matthew Fink, Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔯 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Lincoln Crematory 10/24/11 Brentwood, MD Fort 21. Signatur of Ameral Service Litensee 22. Name and Address of Facility M01102 Simple Tribute KOU 1040 Rockville Pike, Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or linjury that initiated events The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last burialattending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 X No
9 Unknown 3 ☐ Ectopic pregna 5 ☐ Other (specify) for Month Day Year Pregnant at time of death the detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 X Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed Yes 2 K 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate; To Be Other: 4 Nursing Home 5 Residence 6 N Other (Specify) Living 2 🗴 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of

P.O. Box 68760 Division of Vital Records, after death.

Director: After this certificate or Attending Physician: the funeral director, ted filled in by Hospital 24 hours a

28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28d. Describe how injury occurred 1 💹 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one 29b. Signatur

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year)

> October 17, 2011 H45839

Gary E. Raffel, D.O., 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suite 203C, Bethesda, Maryland 20814 5413 West Cedar Lane,

31. Date filed (Month, Day, Year) State

Medical

The The

DHMH 17 Rev 7/2009

29a. Certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla				and M	lental Hy	giene		05000
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of E	Jeath		2. Date of Dea	Reg. No. 2		3. Time of Death
	Physicia		Crummer Farmer						12 ^{Day} 201	1 ^{Year}	11:50AM
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location	of Death		4c. County		
			6207 Joyce Drive Temple Hills								eorges
	Funeral Director		5. Social Security Number 6. Sex 1 XM 2 1 F 7. Age (In yrs	s. last birthday) K Yrs.	If Under 1 Year Months Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Birt 1 2 2 2 2 1	^h ″/ ^Y เลือกร	9. Birthp Coun	olace (State or Foreign try) NC
ļ.	1000		Usual Residence of Decedent	5				12/21	/ 1705		NO
	yland f sho ed at	향		City, Town or Lo						1	0d. Inside City Limits
	e Mar r 28a- notifi	Dire	DC NONE	Washin	gton 10f. Zip Code				40 Citizen of	Malhat Caus	1X Yes 2 No
	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	327 Upshur St. NW		2001	1			10g. Citizen of USA	What Cour	itry:
	death items ner m	Fu	11. Marital Status 12. Was Decedent Ever in Armed Forces?	U.S. 13.1	Was Decedent of Hi f Yes, specify Cuba	ispanic Oi	rigin? (Spe	cify Yes or No- Rican, etc.)		ce - Americ	
36	after al", or xamil	Completed by	Armed Forces? UK1 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No 1 □ Yes, Give 2 □ Widowed 4 □ Divorced		1 □ Yes 2 🖁 No			, ,		Bla	
9	hours natura tical E	lete	15. Decedent's Education	16a. Decer	dent's Usual Occupa	ation			16b. Kind of E	Business Inc	dustry .
2	nin 72 ne. than "	J mo	(Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+)	life. D	kind of work done a O NOT use retired)	during mo	st of work!!	ng	Gener	al S	dustry ervices atlon overnment
2	Hygier other i	BeC	12+h 17. Father's Name (First, Middle, Last)	Carp	enter	18 Moth	har'e Nama	(First Middle	Maiden Surnam		Overimene
Jan	d be fill dental irked o	₽	Crummer Farner, Sr.					ine Bat	-		
lan,	should and N is ma		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street &						Code) 0011
e,	and 2 Health em 27 ther t		Charles Edward Farmer/Son 20a. Method of Disposition	. Place of Dispo	Upshur	St.			20c. Location		
πor	age 1 ent of nt: If it y or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, cren Rest Ha	natory or other plac			5/11	Wilson	-	own, State
Baltimore, Maryland 21215-0036	rmit. P spartm portal y injui		21. Signature of Funeral Service Licensee	22							ome, Inc.
<u> </u>	e a L E E		▶ cc0	2/8 3	831 Geo	<u>rgia</u>	a Ave	e. NW_	<u>Washin</u>		,DC 20011
١.			23a. Part 1. Enter the disease or complications that caused the deshock, or heart failure. List only one cause on each line. Immediate Cause (Final	ath. Do not ente	er the mode of dying	g, such as	s cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
٠.	h, sician/ Medical		disease or condition resulting in death) a. Metasta Due to (or as a conse		ostate	Can	cer			-	
	Examiner	_	Sequentially list conditions, b.								
	₂	nine	if any, leading to immediate Due to (or as a conse	equence of):							
Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							_				
09	e be e ysicial e buria	dical	d								
6876	rtificat ing ph e as th	Med	IF FEMALE:								
Box 6	ath ce attend for use	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Fregnant at the past 12 months? 1 Pregnant at time of	etal death 3	Ectopic pregnanc Other (specify)	y				ate of delive onth	ery Day Year
Ö.	the de	Physician/Me	1 Yes 2 No 9 Unknown 9 Unknown	n double of							
P.0	requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not i	esulting in the u	inderlying cause giv	en in Par	t I.				ne cause of death?
ds	equire been si hould	eted									bably 4 Unknown
Records,	The law rate has be	Completed						24a. Was autop	sy	Were auto prior to co death?	psy findings available mpletion of cause of
<u>e</u>	an: Th tificate tor, pa	Be Co	25. Was case referred to medical		26. Pla	ace of De	ath (Check	1 Yes	2 🖰 No	1 \(\text{Yes} \)	2 L No
Z Z	hysici his cer I direc	To B	examiner? 1 ☐ Yes 2 ☒No Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatier	nt 3 🗆 DOA Othe	er: 4 🗆 N	lursing Ho	me 5 🗌 Resid	lence 6 Oth	ner (Specify	Assisted
Division of Vital	nding Physician: 1 th. : After this certifics : funeral director, p	ate:	27. Manner of Death 1 🔀 Natural 5 🗌 Pending (Month, Day, Year)	28b. Time of injury	work	/ at	2		ow injury occur		-
210	er death ector: by the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At			res 2 L	_			er or Rura	Route Number,
2	ital or irs afte ral Dirr led in l		building, etc. (Spec	uty)				City or Tow	n, State)		
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physician: To the best of my knot (Check 2 Medical Examiner: On the basis of examinal	tion and/or invest	tigation, in my opinio	n, death o	occurred at	the time, date a	nd place, and du	ue to the ca	use(s) and manner stated.
	To the Hospital or within 24 hours after To the Funeral Dir	Σ	only one) 3 ☐ Certifying Nurse Practioner: To the best of 29b. Signature and title of certifier		29c. License		te and place		e cause(s) and m 29d. Date signe		
	5		· Cynthia M William		н005	8032	2		10/13/	2011	
			30. Name and address of person who completed cause of death (It Cynthia M. Williams, DO 37)	em 23a) (Type, F 20 Upt	on St. 1	NW W		ngton	, DC		
	Stat		31. Date filed (Month, Day, Year) 3. Registrar's Sign								
	Registra	ir	OCT 21 2011 Centur /	a. 19 m							

ian	1 - State Registrar 1. Decedent's Name (First, Middle, Last)		2. Date of Death OCLOber	3. Time of Deat 7:10 A						
ical ner	Annie G. Figgs 4a. Facility Name (If not institution, give street and number) Wicomico Nursing Home	4b. City, Town, or Location of Death Salisbury		4c. County of Death Wicomico						
	5. Social Security Number 214-32-2041 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthda 98 Yrs.		8. Date of Birth (Month, Day, Ye							
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location		10d. Inside City Lir						
Director	DE Sussex Delman		10-	1 ☐ Yes 2 X Citizen of What Country?						
Ö	10e. Street and Number	10f. Zip Code 19940	Tog.	U.S.A.						
Funeral	36890 Robinhood Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,						
by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	1 ☐ Yes 2 ☑ No Specify:	o nican, etc.,	Black, White, etc. Specify: white						
Completed	(Specify only highest grade completed) 1 (Gi	edent's Usual Occupation ve kind of work done during most of wor . DO NOT use retired)		b. Kind of Business/Industry						
S	9	Homemaker	(F) 1 14 (1) 1 14 (1)	Home						
Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Mai	den Surname)						
٩	Robert Kirkwood Grant 19a. Informant's Name/Relationship (Type. Print) 19b. Ma	iling Address (Street and Number or Ru	n Mather Iral Route Number, C	ity or Town, State, Zip Code)						
		00 Robinhood Road	Delmar, D							
	20a. Method of Disposition 20b. Place of Disposition	position (Name of rematory or other place)	Date 200	c. Location - City or Town, State						
	1 Burial 2 Cremation 3 Removal from State		15, 2011	Delmar, Maryland						
	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Short Funeral Home 13 East Grove Stre	e eet D el	mar, DE 19940						
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he mit failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):									
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									
I Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):									
dical	d									
Physician/Medi		B⊟Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Yea						
Ş	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3									
lete			24a. Was an	2 No 3 Probably 4 Ponkr						
Completed	25. Was case referred to medical	00 Plant (Pa		prior to completion of caus						
To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat	Other:	ath <i>(Che</i> ck only one) Home 5□ Residenc	ce 6 ☐Other (Specify)						
tion: T	27. Mann of Death 1 Letural 5 Pending (Month, Day Year) 2 Accident Investigation 28a. Date of Injury (Month, Day Year)	of 28c. Injury at	Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred							
Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number State)						
Medical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de and manner stated.									
Me	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)						
	V///M/m/m/w/	DEACIS		10/13/11						

Registrar DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 26 per med cert G923 1/3/12 dk
State of Maryland / Department of Health and Mental Hygiene For State Registrar 35311 Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ \mathbf{P} M 5:45 2011 October 15, Gertrude H. Frazier Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Min. 1 □ M 2 🗶 F **Director** 579-24-1654 Yrs. 89 Nov. 17,1921 **Virginia** Usual Residence of Decede or 28a-f shov 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland items 23a or 28a-f sho her must be notified at Director 1 X Yes 2 No Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral United States 20011 1343 Somerset Place, North West 2. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black "natural", 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)

Administrative the Medical 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government 8th <u>Personnel Supervisor</u> of Health and Mental Hygi item 27 is marked other other traumatic event, i Be permit. Page 1 and 2 should be file.
Department of Health and Mental Hv.
Important: If item 27 is marking any injury or other. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Cora L. Williams Anthony O. Denney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1343 Somerset Place, North West
Washington, District of Columbia 20011 19a. Informant's Name/Relationship (Type, Print) Vicey G. Frazier/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State 10/21/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 22. Name and Address of Facility McGuire Funeral Service, Inc. 7400 Georgia Avenue, North West Washington, District of Columbia 20012 Signature of Funeral Service Houses Chales' Tomas Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ a Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, Examine (to connuipeensor is ee to) of Gut. If any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events that the death certificate be executed e attending physician and ed for use as the buria End Stage COPD Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death the 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by The law requires 1 Yes 2 No 3 Probably 4 X Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? page 2 this certificate Yes 2 K No or Attending Physician: 25. Was case referred to medical Vital director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes မှ 1 X Inpatient 2 ER/Outpatient 3 DOA the funeral 28a. Date of injury (Month, Day, Year) of 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d, Describe how injury occurred within 24 hours after death.

To the Funeral Director. After completely filled in hwat. injury 1 X Natural 5 Pending work?
1 Yes 2 No Division 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

ORATROM

30. Name and address of person who completed ause of death (Item 23a) (Type, Print) Suganthi Alagarsamy Veerappan, M.D.

82. Registrar's Signature

D0067279

October 15, 2011

1500 Forest Glen, Road Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Henry Lee Goslee	1	- For State	tate	of Maryla	-	artment of		nd Mer	ntal Hy	_	Reg. No.	20		3531
Physician Medical Examine	1/	Registrar 1. Decedent's Name (First, Mid Henry Lee G		•			_			2. Date of Dea Month October 3	ath	Year		ime of Death 1359 hrs
		4a. Facility Name (if not institut	ion, give	street and nu	mber)		4b. City, Town, Salisbury	or Location	of Death		4c. C	comico	eath	
Funeral Director	- 1	5. Social Security Number 214-32-0288	6. Se	x M 2 F	7. Age (In yrs. I	ast birthday)	If Under 1 Ye Months Da		der 24Hrs.	8. Date of B		Fo	Birthpla reign Country	
any	Ė	Usual Residence of Decedent 10a. State 10b. County				Town or Locat								. Inside City Limits
	18	MD Wico	mic	0	Sal	isbury	10f. Zip Code			<u>Y</u>	10g. Citizer	n of What C		Yes 2X No
th the Ma 23a or 28 notified	al Director	504 Plover R	oad				21801				USA			Indian Block
frer death wi	y Funeral	11. Marital Status 1 Never Married 2 1 3 XWidowed 4 D		12. Was Deci	2 No		is Decedent of Hes, specify Cub		n, Puerto F			White, etcoeciBla	C.	Indian, Black,
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Amperians 1 fittem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be notified at once.	Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12 1 2		ly highest grad			it's Usual Occup ost of working li					d of Busine		stry
1215-00 The filed with ental Hygiene rrked other to vent, the Me	Be Com	17. Father's Name (First, Middl Ernest T. M	orr					Matt	ie I	First, Middle,				
MD 2. 42 should th and M 27 is m	₽[19a. Informant's Name/Relation Henry L. Go				44 D	ixie (circl		ot 10	, Gr	eenv	ill	^{Code)} 29605 e, SC
MOFE, Pages 1 and tent of Heal tent: If iten		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other	_	Removal fro	om State	Place of Dispos crematory or oth rect C	nerplace) LI !remati	.c .on,		3-201	Do	over,	DE	
Balti permit. Departn Importn injury (21. Signature of Funeral Service	e Licens	Firt	*	Be Fu	lame and Addre nnie S neral	Smith Home	Sa Sa	lisbu	ıry,	MD 2	180	1
Physician /Medical _Examiner	1	23a. Part I. Enter the disease, of failure. List only one caus Immediate Cause (Final disease)	e on ead e a.	ch line. Atheroscler	otic Cardiov	ascular Dis		g, such as	cardiac or	respiratory ar	rest, shock	, or heart		oproximate Interval etween Onset and Death
		or condition resulting in death) Sequentially list conditions,	b.		consequence of								_	
- i	튑	if any, leading to immediate cause. Enter Underlying Caus (Disease or injury that initiated events resulting in death) Last	e c		consequence o								\perp	
be executed sician and urial - transit	dical	UNPENDED	d	AMENDED									_	
	ş	IF FEMALE: 3b. Was decedent pregnant in past 12 months? 1 Yes 2 No 9 U		1 Live b	ant at time of de	2 Fe	tal death 3 her (Specify)	B Ectop	ic pregnar	ncy		Date of deli Ionth	ivery Day	Year
ires that the de signed by the	<u>a</u>	Part II. Other significant cond	ltions	contributing to	death but not r	esulting in the u	underlying cause	e given in P	Part I.					cause of death?
Division of Vital Records, P.O. tal or Attending Physician: The law requires that transfer death. **Al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detac	Completed											prior deat	to comp	y findings available letion of cause of 2 \textstyle No
Vital Rechysician: The this certificate didirector, page	B B	25. Was case referred to medic examiner? 1 ✓ Yes 2 No		ospital: 1	npatient 2	ER/Outpatient		other		nly one) Home 5	Residenc	ce 6 🗸 O	ther: Sce	ene
ion of very seath. tor: After the funeral of the f	tion: To	27. Manner of Death 1 Natural 5 Pe	nding		of Injury Day,Year)	28b. Time of I	njury 28c. Ir	jury at Wor	_	28d. Describe	how injury	occurred		
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,	Certification:	3 Suicide 6 Co	estigation uld not be ermined	28e. Place	e of Injury - At h	ome, farm, stre	et, factory, office	building, e	etc.	28f. Location or Town,		l Number o	r Rural R	Route Number, City
To the Hos within 24 ho Completely	ल				of examination a	ge, death occui and/or investiga								use(s)
	Me	29b. Signature and title of certi	ier 4	ME)			nse numbe C.M.E.	r			ete signed oer 4, 20	,	Day, Year)
3 TOA		30. Name and address of person Melissa Brassell, MD			e of death (Item dical Exami		/. Baltimore	Street, F	Baltimor	e, MD 212	23			
Stat	-	31. Date filed (Month, Day Yea	1 2	32. Re	gistrar's Signati	lire &	and f		_					

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35313 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jeffrie Ann Horn 12:48 AM 2011 October 0 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 181 Stanford Rd. Hagerstown Washington County Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) **Funeral** 209-46-1457 **Director** 1 □ M 2 □XF 56 Feb. 4,1955 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location with the Maryland Director 10d. Inside City Limits Maryland Washington County Hagerstown 1 Yes 2X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or edical Examiner must be r Funeral 181 Stanford Rd. 21742 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 X Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify 3 Widowed 4 Divorced Specify: White Completed er than "natur , the Medical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) ulth and Mental Hygiene.
27 is marked other tha Insurance Agent Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert William Kistler Audrey Yvonne Lyons Kistler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other trong. Ronald L. Horn-husband 181 Stanford Rd. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 10-26-2011 | Smithsburg, MD ture of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or leach fine. Approximate Interval Between Onset and Death ende Immediate Cause (Final Physician/ disease or condition Introm! Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or injury that initiated events attending physician and or use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of deliven 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Director: After this certificate 2 🗆 No Yes 2 IN 1 Tes funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes Hospital 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 \sum Yes 2 \sum No iniury 5 Pending Accident Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c License number lderic LA 3658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11110 31. Date filed (Month State

Registrar

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			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.								
			For State	State of Maryland				•		1 1	35314
			Registrar		Cer	tificate of L	Death		Reg. No 2 U		
	Physicia Medic		Decedent's Name (First, Middle, Last) Clarence Edward Ho:					2. Date of Dead Octobe	r 20 201	Year	3. Time of Death 5:50 P M
	Examir	er	4a. Facility Name (if not institution, give stre Broadmore Assisted			4b. City, Town, or Hagers	r Location of Death town		4c. County Washir	of Death 1gton (County
	Funeral Director			7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Da Sept.		9. Birthplac Country Mary L	ce (State or Foreign and
	tryland a-f show ied at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Washington		Town or Loc					10d	Inside City Limits
	ith the Ma 23a or 28k st be notif	Funeral Director	10e. Street and Number 1175 Professional			10f. Zip Code 21742			10g. Citizen of V	-	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ		Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 N No If Yes, Give Year or Dates.			lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Blac	e - American k, White, etc	
Maryland 21215-0036	in 72 hour e. nan "natu t Medical	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed) College (1-4 or 5+)	(Give F life, D	O NOT use retired)	pation during most of work	ing	16b. Kind of Bu		
121	d withing the state of the stat	Be C	12 17. Father's Name (First, Middle, Last)		Assem	bler	18. Mother's Nam	o /Eirot Middle	Departn		tore
yland	uld be file I Mental I narked c	To	John R. Horst				Sarah Ja	ne Angl	e		
	12 shoualth and 27 is n		19a. Informant's Name/Relationship (Type, Leo R. Horst / Bro	. 1			and Number or Rur venue, Wi				
Baltimore,	Page 1 and ment of Hea ant. If item any or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	20b. Pla	ice of Dispo	sition (Name of natory or other plac	ce)	Date	20c. Location -	City or Town	
Balti	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	Zin		. Name and Addres	ss of Facility Do	uglas A N.Hager	. Fiery	Funer	al Home nd 21742
	Physician Medical		23a. Part 1. Enter the disease, or complications, or heart failure. List only one of immediate Cause (Final disease or condition resulting in death)	tions that caused the death. ause on each line. Due to (or as a conseque)	Do not ente	er the mode of dyin				A	pproximate iterval Between inset and Death
	Examiner		Sequentially list conditions, b.	COVOY	nary	Arte	y D	15005	2		
	ath certificate be executed attending physician and for use as the burial-transit	l Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent	ad	Fibri	hation				
68760	ate be physici the bu	edica	d								
Box	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the b.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	If yes, outcome of pregnand Live Birth 2 Fetal of 4 Pregnant at time of de Unknown	death 3	Ectopic pregnand Other (specify)	су		23d. Dat	e of delivery	ay Year
s, P.O.	requires that the deripeer signed by the should be detached		Part II. Other significant conditions contri	outing to death but not resul	ting in the u	nderlying cause giv	ven in Part I.		obacco use contr		cause of death?
cords	law requi nas been e 2 should	Completed by						24a. Was	an 24b. V	Vere autopsy prior to comp	r findings available eletion of cause of
I Re	in: The ificate or, pag		25. Was case referred to medical		<u> </u>	26 PI	ace of Death (Chec	1 Yes	ormed? c	leath?	□ No
Vita	ysicia is cert direct	To Be	examiner? 1 Yes 2 No Hos	pital: 1 ☐ Inpatient 2 ☐ El	R/Outpatien	Oth	er.		dence 6 Othe	er (Specify)	Assisted
on of	nding Ph ath. r: After th ne funeral	Certificate: 7	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		8b. Time of injury	28c. Injun	y at		now injury occurre		Living
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	l Certif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (S City or Tow	Street and Numbern, State)	er or Rural Ro	oute Number,
	he Hospil in 24 hour he Funera ipletely fill	Medical	(Check 2 Medical Examiner:	n: To the best of my knowled On the basis of examination a ractitioner: To the best of my	and/or invest	igation, in my opinio	on, death occurred a	t the time, date a	and place, and due	to the cause	(s) and manner stated. ed.
	with with com		29b. Signature and title of certifier Tour	4		29c. License	6 0 3 9 6		29d. Date signed	(Month, Da)	/, Year)
	1		30. Name and address of person who comp	1 1 . 2	23a) (Type, P	rint) 112	6 OPA	1 0	Had	235	My
	Sta	te	31. Date filed (Month, Day, Year)	32. Legistrar's Signatur	A A	200			7	AA/D	ナソナン

			1 - For State Registrar	State of Maryland / I	Department of Health and Certificate of Death	Mental Hygie						
			1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death					
	Physici /Medio		Ella Ha	yes		Oct. 10	2011 1:45 P M					
	Examir		4a. Facility Name (If not institution, give s		4b. City, Town, or Location of Dea		4c. County of Death					
			South River Reh				nne Arundel					
	Funeral		5. Social Security Number 6. Sex 1 6. S	M 287 F	Yrs. Months Days Hours Min	. (Month, Day, Ye.						
	Director		Usual Residence of Decedent	97		4/14/19	14 NC					
	ylend		10a. State 10b. County	10c. City, Tow	n or Location		10d. Inside City Limits					
	a-fsh	ctor	MD Prince	Georges Lan	ham		1 XYes 2 □ No					
	or 28	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?					
	238		7217 Lois Lane		20706		ŞA					
	tems	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc.					
36	rs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🔯 Widowed 4 ☐ Divorced	1 □ Yes 2 MNo If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:		Specify:					
21215-0036	72 hours after death with the Marylend natural', or Items 23s or 28s-1 show liteal Exeminer must be mailised at	ed	15. Decedent's Educ		. Decedent's Usual Occupation	16b	Black Kind of Business/Industry					
215	within 73 ene. than "n	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done during most of we life. DO NOT use retired)	orking						
21	giene.	Corr	12th		Domestic Worker		Private Industry					
В	sal Hygie d other	Be (17. Father's Name (First, Middle, Last)		18. Mother's Na	ime (First, Middle, Maid	den Sumame) Unknown					
yla	should be nd Mental marked o	2	James Williams									
Maryland	01 02 09 00		19a. Informant's Name/Relationship (Type		o. Mailing Address (Street and Number or F							
	1 and 2 Health em 27	H			212 Lois Lane La		Location - City or Town, State					
Baltimore,	0 = 0	1	1 Burial 2 ☐ Cremation 3 ☐ R	emoval from State cemete	ry, crematory or other place)							
Ħ	permit. Pa Departmer Important: any injury	1	4 □ Donation 5 □ Other (Specify)21. Signature of Funeral Service License		ington Natl. 10		uneral Home, Inc.					
Ba	permi Depa Impo any ir		· A	cc0278		_	shington, DC 2001					
			23a. Part 1. Enter the disease, or compli	cations that caused the death. Do	not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between					
	Physician		23a. Part1. Enter the bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Shock, or heaft failure. List only one cause on each line. Immediate Cause (Final disease or condition a. A the voscle 70 to Covdro voscul									
	/Medical		resulting in death)	Due to (or as a consequence		743W/W	293.027					
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Н	B /3	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
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58760,	rtificate be executed ng physician and as the burial traper	aiE										
687	ficate p phys	edicai										
Вох	eath certil attending for use a		IF FEMALE: 23b. Was decedent pregnant 25	3c. If yes, outcome of pregnancy	• 🗔 -		23d. Date of delivery					
m.	Q 0 Q	icia	in the past 12 months? 1 ☐ Yes 2 ⑤No	1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month Day Year					
P.O.	that the deatt ed by the atte detached for	Physician/M	9 🗆 Unknown	9□ Unknown								
	Se un ec	by F	Part II. Dther significant conditions con				co use contribute to the cause of death?					
ord	w require been sign	ted		ge Deme	7) +) 4	1 🗌 Yes	2 No 3 Probably 4 Nnknown					
ec	has b	Completed	Dysphogi	0.		24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of					
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	ding f th. : After s funer	tior	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b.	Time of lnjury at Work? M 28c. Injury at Work? 1 □ Yes 2 □ No							
Division	Atter r dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home, fa	arm, street, factory, office		t and Number or Rural Route Number,					
Ö	s afte	Certification;	4 L Homede	building, etc. (Specify)		City or Town, S	1010)					
	ospit hour uners		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge	e, death occurred at the time, date and placedor investigation, in my opinion, death occ	ce, and due to the cause	e(s) and manner as stated.					
	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After bompletely filled in by the funer	Medical	опе)	and manner stated.								
	of with	2	29b. Signature and title of certifier	- C.	29c. License number	29d.	Date signed (Month, Day, Year)					
	5		-cryan	e smono	1 050005		0.10.2011					
			30. Name and address of person who co	mpleted cause of death (Item 23a)	29c. License number D 50653 (Type, Print) G Y A N WYON ROACE	C. 5U	RA 10 14 2 2751					
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature	mien kond	Deale	- 111.0 50121					
	Registr		DOT 2 1 2011	6 6	a Kar							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:30p Physician/ Joseph Haddad 00t.14, 2011 Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hebrew Home Of Washington Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign Days Min. 1 X M 2 □ F 219-25-8604 Hours 90 3 MOB PA 921 Lebahon Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location
Temple Hills 10d. Inside City Limits Director MD Prince George' 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3307 Huntley Square Dr. #A1 20748 USA death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No should be filed within 72 hours after dand Mental Hygiene.
is marked other than "natural", or i Black, White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Deebeh Abudhaher Haddad ္ပ Najeeb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Page 1 and 2 sl tment of Health a tant: If item 27 is Enat Haddad/Daughter 3307 Huntley Square Dr. #A1 Temple Hills, Md other 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crem. 10/19/201 Beltsville, Md 4 ☐ Donation ★ ☐ Other (Specify) PHALL PAD SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ lementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 'ar Kinsons Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy performed? ☐ Yes 2 No 1 Yes Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital: Certificate: To 1 🗌 Yes 2 X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Phymin 24 hours after death.

To the Funeral Director. After the Completed filled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) miner Feizle D0064871 10-14-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Montrose Rd 6121 Mina fazli, MD Rockville MD 31. Date filed (Month, Day, Year) State Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 10-20-20 Pay 2050 PM Joseph Perry Hargis, Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Citizens Care Center Harford 5. Social Security Number f Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Days 1 M 2 □ F 218-14-8667 86 01-20-1925 Maryland Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Evander must be notified at 1 □Yes 2 No Maryland Harford Directo Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code UnitedStates of America 21078 4154 U Way Funeral permit. Pages 1 and 2 should be filed within 72 hours after death vale bepartment of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must any injury or other traumatic event, the Medical Examiner must once. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 □ No WWII If Yès, Give Year or Dates: Konea 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Civil Service Machinist Model Maker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Elma Andrew Joseph P. Hargis, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4154 U Way, Havre de Grace, Maryland 21078 Carolyn A. Hargis (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State RA Ferris & Co. Inc. 10-24-2011 WestChester, Pennsylvania 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Zulman Funeral Rome, T.A 21078 123 S. Washington St., Havre de Grace, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). law requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ospital or Attending Physician: The hours after death. certificate 2 1 No 1 □Yes 1 ☐ Yes 25. Was case referred medical Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yeş this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of Injury (Month, Day, Year) 27. Man r of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mo) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 15, 2011 8:45 Ам John Jay Harling Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Temple Hills Prince George's 6615 Howie Court Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex 1 M 2 D F 9. Birthplace (State or Foreign **Funeral** Octonth, Pay, Months Year 946 Director DC 577-62-2372 Yrs 65 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Temple Hills 1 X Yes 2 No Maryland |Prince George's ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a of the Medical Examiner must be Funeral 6615 Howie Court 20748 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. African 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed American Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Metropolitan 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Police Officer Government Department of Health and Mental Hy, Important: If item 27 is marked other any injury or other traumatic event, once. Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lonnie W. Harling Sr. Carrie Kemp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Temple Hills, Maryland Gwendolyn F. Harling - Wife 6615 Howie Court 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State October 2011 22 4 Donation 5 Other (Specify) Harmony Landover, Maryland 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. Jun 4001 Benning Road NE Washington, DC 23a Ran 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Metastatic Breast Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence bij. as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ρ þe 1 Tes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: 잍 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 24 hours Medical 29a. Certifier **Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆

To the within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ate filed *(Month, Day,* Yea. OCT 2 0 2011 State

only one)

29b. Signature and title of certifier

Thu Nguyen MD 6104 Old Brance Avenue

Registrar

29c. License number

D0058686

Temple Hills, Maryland

29d. Date signed (Month, Day, Year)

October 19, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Date Month Physician/ 04:57AM 2011 Linwood O. Holloway Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice at LISBULL WICOMICO Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Min. Hours Maryland 0777817928 83 **Director** 213-24-0745 Usual Residence of Decedent show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 🗌 Yes 2 🔀 No Maryland Wicomico Parsonsburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 32880 Mt. Hermon Rd. iral", or items? Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Completed by 1 X Yes 2 No
If Yes, Give Marine
Year or Dates Corps 1 Never Married 2 K Married altimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural" White 3 Divorced 4 Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Coca Cola Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Ralph C. Holloway Maggie Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra 32880 Mt. Herman Rd. Parsonsburg MD 21849 Ruth Holloway Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \square Burial 2 \boxtimes Cremation 3 \square Removal from State Salisbury Crematory 4 Donation 5 Other (Specify) 10|07|2011 |Salisbury MD Signature of Funeral Service Licensee 22. Name and Address of Facility Holloway Funeral Home P, A. Snow Hill Rd Salisbury MD, 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ PROSTATE MALIGNANT disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? Yes 2 N 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident M Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 1:15AM BOBBY KENNETH HAMLETT AKA ROBERT 2011 Medical 05 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WORCESTER 704A ANCHOR CHAIN ROAD OCEAN CITY Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 7. Age (In vrs. last hirthday) 9. Birthplace (State or Foreign 1 XM 2 □ F Min. Months Days Hours Vrs TENNESSEE Director 408-52-6415 78 1933 APRIL be filed within (2 10.0...) lental Hygiene.
Inted other than "natural", or items 23a or 28a-f snowarked other than "natural", or items 23a or 28a-f snowarke event, the Medical Examiner must be notified at Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MARYLAND WORCESTER OCEAN CITY 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 21843 704A ANCHOR CHAIN ROAD 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Was Decedent Ever III 0.5. Armed Forces? 1 ▼Yes 2 No If Yes, Give Year or Dates. 1954–57 Black, White, etc. 1 Never Married 2 Married ģ Subby Hamlett altimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d 2 should be filed with alth and Mental Hygien 127 is marked other th HEAVY EQUIPMENT OPERATOR CONSTRUCTION 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ STOUT C. GEORGIA C. HERMAN HAMLETT injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 74 OCEAN PARKWAY, BERLIN, MARYLAND 21811 BRUCE M. HAMLETT/SON Important; If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State oţ 1 🗆 Burial 2 Xcremation 3 🗆 Removal from State cemetery, crematory or other place, 4 ☐ Denation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 10/7/11 DELMAR, DELAWARE 21. Signatur 22. Name and Address of Facility <u>HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975</u> Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ CARCINDONA MALIGNAN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to lor as a consequence of if any, leading to immediates. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events tran and Due to (or as a consequence of): resulting in death) Last burial Physician/Medical Division of Vital Records, P.O. Box 68760 phys the L nding IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? jo Pregnant at time of death
Unknown ed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed Yes 2 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 욘 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 🗆 Nursing Home this 27. Manner of Death

Natural

Accident

Suicide filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: All completed filled in by the fu Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier EXE 10 SAses Buff up 21802 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar aHuran

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31. Date filed (Month, Day, Year,

R

Registrar's Signatu

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Ba

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2:43 Ray Hubert Jewell Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington County Hagerstown If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. Social Security Number 9. Birthplace (State or Foreign . Age (In vrs. last birthday 8. Date of Birth **Funeral** 1 XM 2 □ F Feb. 20 West Virginia 182-14-1437 Director 96 7915 Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 18645 Crestwood Dr. 21742 U.S.A. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 alth and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer 8 Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Emmanuel Jefferson Jewell Martha Magdeline See 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is Jennifer Fraley-daughter 18645 Crestwood Dr. Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 10-21-2011 | Hagerstown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) neumania Medical **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ysician a e burial-1 Physician/Medical Box 68760 phy: IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Pregnant at time of death 5 Other (specify) nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiomyopathy Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes ■ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physical within 24 hours after death.

To the Funeral Director: After this a completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident
Suicide
Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 2ga Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D50362 antin 1 m0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 Pennsylvania Ave. Hagerstown, MO 21742 31. Date filed (Month 32. Fegistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Month Physician/ Johnson Robert 11:55 PM M Oct. 18 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Potomac Manor Care Potomac Montgomery Social Security Number 8. Date of Birth
(Month, Day, Year)
Jan. 28,1929 If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Months Hours Min. 1 X M 2 D F 82 280-24-5367 Ohio Yrs **Director** Jan. Usual Residence of Decedent show 10a State 10b. County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 20854 11104 Lamplighter Lane U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 □ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, other traumatic event, the Medical Examiner Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Year or Dates. Vietnam 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Patent Office Patent Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Alice Hancox Lawrence A. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Fuscoe (Sister) 11104 Lamplighter Lane, Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 Toremation 3 ☐ Removal from State Metropolitan October 19 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, VA Crematory 21. Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home TRACY A. JTUVEL MO1117 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Pulmonary Fibrosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and Cause (Disease or iinjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached f P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Debilitated Records, Completed 1 X Yes 2 No 3 Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law has page 2 autopsy performed' death? certificate Yes 2 X No 2 🗌 No 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? 1 Tyes 2 🗶 No Other: ျ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 X Nursing Home 5 - Residence 6 - Other (Specify) this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred nin 24 hours after death.

the Funeral Director: After in pleted filled in by the funeral 1 X Natural 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 🗆 To the Vithin 24 Certifying Nurse Practioner: To the best of my knowledge, death oc urred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) let D50534 October 19, 2011 orners

Registrar
DHMH 17 Rev 7/2009

State

32. Registrar's Signature

Thomas Masterson, M.D., 6858 Old Dominion Drive #104, McClean, VA 22101

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)
OCT 20 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 10-11-2011 1:54 AM Catherine Marie Jones 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bivalve Under 1 Year | If Under 24 Hrs. 21124 Nanticoke Rd
5. Social Security Number | 6. Sex Wicomico Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Min. 1□ M 2□**x** Months Davs Hours 9-21-1963 DE. 48 221-50-4110 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 □Yes 2 □ No MDWicomico Bivalve 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21124 Nanticoke RD 21814 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2 ☑ No Specify:White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 <u>Secretary</u> Legal 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Barbara Flowers Robert Czerny 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Jones husband 21124 Nanticoke RD Bivalve,MD 21814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Bivalve Cemetery | 10-14-11 Bivalve, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Meni, Bessick Funeral Home PO Box 6121814 M00416 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatec Molignant Melanon ycors disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

permit. Pages 1 and 2 should be filed wil Department of Health and Mental Hyglen Important; If item 27 is marked other than any injury or other traumatic event, Item

Physician

/Medical

Examiner

Funeral

Director

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Director

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Completed

Be

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Examiner

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Completed

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Certification: To

Medical

7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Exeminar nust be notified at

Baltimore, Maryland 21215-0036

and burialattending physician for use as the buria signed by the a be detached f page 2 s certificate

Box 68760

P.O.

Records,

Division of Vital

law requires that the death certificate be executed Physician: The After this certifical funeral director, I Hospital or Attending n 24 hours after death.

e Funeral Director Af eletely filled in by the fur completely within 2 To the 1

UTE

MAZTIN E State Registrar

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

30. Name and address of person way completed cause of death (Item 23a) (Type, Print) M.O. 100 Registrar's Signature

and manner stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

M.D.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D30690

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Carroll St. Solisbury MD 21801

29d. Date signed (Month, Day, Year) Oct. 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month : 40 PM Medical Steven Dale Jones **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Salisbury 4c. County of Death WICOMICC at the If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗶 M 2 🗆 F Min. 212-04-3666 024915 17970 Director MaryTand Yrs 41 Usual Residence of Decedent 10a State 10h County within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits notified 28a-f 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number č 10f. Zip Code ms 23a or must be r 10g. Citizen of What Country? Completed by Funeral 36056 Old Ocean City Rd. 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Truck Driver Transportation Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Milton Jones Mary Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 36056 Old Ocean City Rd., Robert Jones father Salisbury, Maryland 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Anatomy GITTS 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 10 10 2011 Hanover, Maryland Registry 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Holloway Funeral Home P.A. Snow Hill Salisbury, Maryland 21804 Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MALIGNAN BCADDRR disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Directo for selection actions of If any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last and inding physician are use as the burial-t Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Let Fetal death 23b. Was decedent pregnant atten for us 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year the 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2/2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed ves 2 certificate 1 Ves 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes Other: 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 4 Nursing Home 5 Residence funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident 5 Pending injury nours after death.

neral Director: After
filled in by the fun 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D completed filled i Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D0058410 10-07-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TE

State

31. Date filed (Mont

Registrar

DHMH 17 Rev 7/2009

istrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year 1:40 Рм Charles Johnson Jr. 2011 Medical 10 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Capitol Heights 9202 Nyanga Ave Prince George's 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 10 Pay, Yar 935 1 🕱 M 2 🗆 F Months Yrs DC: Director 577-44-5844 Usual Residence of Decedent i show ms 23a or 28a-f shor must be notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Md Prince George's Capitol Heights Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 9202 Nyanga Ave 20743 death items al Hygiene. d other than "natural", or items event, the Medical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ğ 1 Never Married 2 Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 XDivorced Specify: Black Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12TH College (1-4 or 5+) SUPPLY CLERK FEDERAL GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental | မ traumatic CHARLES P. JOHNSON DAISY MAE RAGIN e 1 and 2 should be of Health and Me fitem 27 is mark rother traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5105 ILLINOIS AVE, NW, WASHINGTON, DC 20011 <u>Sharon Johnson/ Daughter</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of I Important: If its any injury or of 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Maryland Veterans 10/25/2011 CHELTENHAM, MARYLAND 4 Donation 5 Other (Specify) Cemetery at Cheltenham Pope Funeral Homes, P.A. Signature of Funeral Service 22. Name and Address of Facility 0108 5538 Marlboro Pike, Forestville, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Fatal cardiac arrhythmia Medical resulting in death) Due to (or as a consequence of) **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and s the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) ō in the past 12 months? Month Day Year Pregnant at time of death the Unknown 9 Unknown P.O. signed by to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed prior stroke, diabetes mellitus peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? 2 🗌 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 X Yes 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 1 Natural 4 hours after death.

uneral Director. After the funeral of filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State thin 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1221

McConnell:

J Wendell

D0029654

Mercantile Lane, Upper Marlboro, MD 20774

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 249 Edward Robert Kennett talpr Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Char **Funeral** 5. Social Security Number . Age (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State or Foreign 1 X M 2 □ F Months Hours Min. (Month, Day, Year) 1/18/1954 Mary Land **Director** 219-72-3480 Usual Residence of Decedent items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any inlury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Tes 2 X No Maryland | St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 37663 Jack Gibson Road 20609 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Genevieve Delahay Edward Kennett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20609 <u>George Kennett/Brother</u> Box 47, Avenue, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Dopation 5 ☐ Other (Specify) Brinsfield-Echols Cre10/25/2011 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 Margaret H. Hicks M01631 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a Id be detached for 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has b lirector, page 2 sl performed? Yes 2 No Yes 2 □ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation filled in by the Accident
Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined n 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

5) pme

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 4.10 PM Month Physician/ KTOBER OLANI 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, **Examiner** Montgomery Burtsonville Sanctuary At Holy Cross 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month, Min. Country) 1 ☐ M 2 🕱 DC 1954 56 Director 250-04-1361 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location at 10a. State Director 1 X Yes 2 □ No the Medical Examiner must be notified Laure1 MD Prince George's 10g. Citizen of What Country? 10f. Zip Code ь 10e. Street and Number Funeral "natural", or items 23a Prince George's 20708 8701 Char Court Apt.#22 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify Specify: If Yes, Give **Black** Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event "to once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Lobby Attendant Supervisor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Agnes Mildred Alexis Wilbert Ullyss Edwards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8701 Char Court, Apt.# 22, Laurel, Maryland 20708 Charles King/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 10/24/2011 | Laurel, Maryland Maryland National 4 ☐ Donation 5 ☐ Other (Specify) Pope Funeral Homes, P.A. 22. Name and Address of Facility M00981 21. Signature of Funeral Service Licensee 5538 Marlboro Pike, Forestville, MD 20746 Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to for as a consequence of Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day been signed by the atte should be detached for 4 Pregnant at time of death
9 Unknown 9 Unknown Part II. Pther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PAILURE 1 Tes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Certificate: To Be examiner? Other: Hospital 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No Investigation Accident 6 🗆 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 28595 121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SMITH AUF BACK

State Registrar

Date filed (Month, Day, Year,

24

2011

		•	State Registrar			Cer	tificate of D	Death		R	leg. No.	
	Dharisis	_,	1. Decedent's Name (First, Middle, L	ast)					:	2. Date of Deat Month		3. Time of Death
	Physicia Medio		Harry Ric	lgney Lea	asure					October	r 20, 2011	11:20 A M
	Examin	er	4a. Facility Name (if not institution, gi				4b. City, Town, or		f Death		4c. County of Dea	
-1			6227 Clevelandt				Boonsbo				Washin	
	Funeral Director		219-07-3454	Sex 1 🕅 M 2 □ F	(In yrs. last I	birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours		B. Date of Birth (Month, Pay, eb 15	Year) 1919 Ma	rthplace (State or Foreign ountry) ryland
	d Jow	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
	rylan I-f sh ied a	Director										1 ☐ Yes 2 🛣 No
	e Ma r 28a notif	Oire	Maryland Washing	gton	Воо	nsbo	10f. Zip Code				10g. Citizen of What C	
	s 23a o	Funeral I	6227 Cleveland	own Road			21713	}			U.S.A.	ountry?
	death item ner n		11. Marital Status	12. Was Decedent Ev Armed Forces?		1 1	Vas Decedent of Hi Yes, specify Cuba	ispanic Origi n, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)	14. Race - Am Black, Whi	
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy filury or other traumatic event, the Medical Examiner must be notified at once.	ed by	1 ☐ Never Married 2 🖾 Married 3 ☐ Widowed 4 ☐ Divorced	1 🕅 Yes 2 🗆 N If Yes, Give Year or Dates.	₀1943. 194	1 1	☐ Yes 2 X] No	Specify:				Thite
5-0	72 hou n "natu ledica	Completed	15. Decedent's (Specify only highest of		1	(Give I	lent's Usual Occupa	ation during most o	of working	,	16b. Kind of Business	Industry
2	ene. thar	Con	Elementary/Seconday (0-12)	College (1-4 or 5-	+)		NOT use retired) Worker				Manuf	acturing
7	Hygi Hygi othel ent, t	Be	17. Father's Name (First, Middle, Last)		TITIL	WOLKEL	18. Mother	r's Name (First, Middle, N	Maiden Surname)	
<u>a</u> n	be fi lental rked ic ev	으	Harry Leasu	e				Vir	ginia	a Bel	le Whort	on
Maryland	hould and M s ma umat		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	ig Address (Street a	and Number	or Rural F	Route Number,	City or Town, State, Z	ip Code)
Σ	d 2 s alth a n 27 i er tra		Rachel I. Leası	re / wife	1	6227	Clevelan	dtown	Road	d Boons	boro, Mary	land 21713
ore,	of He fiten		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	7 B Otata	20b. Place	e of Dispo	sition (Name of natory or other plac	e)	Da	te	20c. Location - City o	r Town, State
<u>ĕ</u> .	Page ment ant: I ury o		4 Donation 5 Other (Spe		1		Vet. Cer		l0 – 25	-2011	Flintston	e, Maryland
Baltimore,	permit. Departi Import any inj		21. Signature of Functal Samue Lice	Asee A							fer Funera	11 Home, PA 21713
		_	23a. Part 1. Enter the disease, or co	mplications that aused	the death. D							Approximate
ا بند	Physician/		shock or heart failure. List only Immediate Cause (Final	one cause on ach line.	_			-				Interval Between Onset and Death
	Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	11956 ce of):	op D	120	ase	<i></i>		2 Syears
	Examiner				001100400110	33 3.7.						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequenc	ce of):						
	icate be executed g physician and s the burial-transit	Examiner	Cause (Disease or linjury that initiated events	C								
_	oe exe Ician a	alE	resulting in death) Last	Due to (or as a	consequent	Je 01).						
38760	cate the phys the i	Medical		d								
.89	sertific nding use as		IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outcome o							23d. Date of d	elivery
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 64 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live Birth 2 4 ☐ Pregnant at 9 ☐ Unknown			Ectopic pregnanc Other (specify)	;y			Month	Day Year
<u>O</u> .	that th ned by detac	y Ph	Part II. Other significant conditions					en in Part I.		23e. Did to	bacco use contribute t	to the cause of death?
S,	puires en sign uld be	ed b	Co	onary	an	ery	1 605	au.	se	1 🗆 Y	′es 2 No 3 □	Probably 4 🗌 Unknown
COL	aw rec as bee 2 sho	Completed	De	genera	lor	20	arthr	175	<u> </u>	24a. Was a	sy prior to	utopsy findings available completion of cause of
Re	The l	Con		0						performula 1 Yes		es 2 No
ta	cian; sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:			26. Pla	ace of Death				
₹	Physi this c	- To	1 ☐ Yes 2 XNo 27. Manner of Death	1 Inpatie	-	Outpatien b. Time of	t 3 🗆 DOA	4 ∐ Nur			ence 6 Other (Spe	cify)
0 u	ding h. After funer	ate	1 Natural 5 ☐ Pending	(Month, Day,		injury	work	yaı ? Yes 2□1		a. Describe no	ow injury occurred	
Sio	Atten	Certificate:	2 Accident Investigati 3 Sulcide 6 Could not 4 Homicide determine	be 280 Place of Injur	y - At home	, farm, stre		100 2 2 1	_	3f. Location (St	treet and Number or R	ural Route Number,
$\overline{\underline{S}}$	al or safte		4 🗆 Hottlicide — determine	building, etc.	(Specify)					City or Town	n, State)	
	lospit I hour unera	Medical		ysician: To the best of n								tated. e cause(s) and manner stated.
	the H nin 24 the Fu nplete	Me	only one) 3 Certifying Nu	rse Practioner: To the b	est of my kn	owledge, c	leath occurred at the	e time, date a	and place,	and due to the	cause(s) and manner a	s stated.
	Vith Con		29b. Signature and title of certifier	1 1 -			29c. License	number 14 G G	16	2	29d. Date signed (Mon	th, Day, Year)
	1			1 -				1-1-			U CA USC	3
	5x		30. Name and address of person who	completed cause of de	ath (Item 23:	a) (Type, P	rint)	311 6	ap	pans	Rol Doo	nsbno MD 21713
	Stat	e	31. Date filed (Mont) Yes	32. egistrar	's Signature	1 4	had					

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	Physicia		1. Decedent's Name (First, Middle, Las Lena Jean Le								2. Date of De Month	ath 1 P	ay	Year 11	3. Time of D	
m 1	Medi Exami		4a. Facility Name (if not institution, give				4b. City, T	own. or	Location (of Death	Oct.	10	- 2 (c. County		4:30	A W
market a	}. =		9509 Blanchard				Ft.		shin		1		,		Georges	5
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. la	st birthday)	If Under		If Under Hours		8. Date of Bir	th			nplace (State or F	
	Director		Usual Residence of Decedent	- X 0	4	Yrs.					6/7/1	947			DC_	
	rland F shov	ţō	10a. State 10b. County		10c. City	, Town or Loc	ation								10d. Inside City	Limits
	Mary 28a-1 notifie	Director		Georges	Ft	Was	hingi								1 X Yes 2	! □ No
	ith the		10e. Street and Number				10f. Zip (_	itizen of V	Vhat Cou	intry?	
	eath w	Funeral	9509 Blanchard	Drive 12. Was Decedent Ev	ver in U.S.	. 13. W		7 4 4		gin? (Spe	cifv Yes or No-		JSA 14 Bace	- Amer	ican Indian,	
9	fter de , or it amine	β	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔀 N							cify Yes or No- Rican, etc.)			k, White		
8	ours af tural" al Exa	Completed	3 Widowed 4 X Divorced	If Yes, Give Year or Dates.		1	☐ Yes 2	X⊾ No	Specify:				Specify:	Bl	ack	
15-	72 ho n "na fedic	nple	15. Decedent's E Specify only highest gra				ent's Usual ind of work NOT use r	done du		t of worki	ng	16b. I	Kind of Bu	ısiness I	ndustry	
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pu	filed tal Hy d oth	o Be	17. Father's Name (First, Middle, Last) James Dorsey John W. McClas		•				18. Mothe	er's Name	(First, Middle,	Maiden	Surname			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	입									Mae Do					
Mai	2 shorth and 27 is r		19a. Informant's Name/Relationship (T)			19b. Mailing 2923	g Address (Street ar	nd Numbe	er or Rura	l Route Numbe	er, City o	r Town, S	tate, Zip	Code)	
ē,	f Heal item		Robbie J. Lewis 20a. Method of Disposition		20b. Pla	29 B	ition (Name	e of			01 Ten				MD 207	748
mo	Page nent o int: If		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	ce	metery, crem hingt	atory or oth	er place		_	18/11			•		
Baltimore,	permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licens		1	22.	Name and	Address	s of Facility	y Lat	ney's	Fu	nera	al I	ome	
-	2018				c027								hing	gtor	,DC 20	011
	Physician Medical Examiner		23a. Part 1. Enter the disease or comp shock, or heart failure. Ust only of Immediate Cause (Final disease or condition resulting in death)	ne cause of each line.	the death.	and	the mode	of dying	, such as	cardiac o	r respiratory ar	rest,		_	Approximate Interval Betwe Onset and De	
	e executed vian and urial traveit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	b. — Doe to (or as a												
	cate be exe physician a the burian		resulting in death) Last	Due to (or as a	conseque	ence ot):										
. Box 68760	in one nospital or Attending Prystician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the but		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Petal	death 3 🗌	Ectopic pro Other (spec		,				23d. Dat Mor		very Day Yea	ar
P.O.	that the ned by a deta	by PI	Part II. Other significant conditions co	ontributing to death bu	t not resul	lting in the un	derlying ca	use give	n in Part I		23e. Did t	obacco	use contri	ibute to	the cause of dea	th?
ds,	quires en sig tuld by	led t									1 🗆	Yes 2	X No	3 APR	obably 4 🗌 Un	known
Division of Vital Records,	The law restate has be page 2 sho	Completed									24a. Was auto perfo	psy ormed?	, p	rior to co leath?	opsy findings ava ompletion of cau	ailable se of
ita	sician: The certificate rector, pagi	0	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:				Othor	ce of Deat							
ر آ	rthis eral di	e: 10	27. Manner of Death	28a. Date of injury	/ 2	R/Outpatient 28b. Time of		c. Injury	4 ∐ Nu		ne 5 Resid				y)	
ouc.	nding ath. r: Afte ie fune	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day,	Year)	injury	М	work?		- 1	ou. Describe i	low injur	y occurre			
Division	ure nospiral or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific Completed filled in by the funeral director.	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	building, etc.	(Specify)						City or Tov	vn, State	e)		N Route Number,	
	Prosp 24 hou Fune leted fil	Medical	(Check 2 \(\subseteq Medical Examin	sician: To the best of m	amination a	and/or investig	gation, in my	y opinion	, death oc	curre d at 1	the time, date a	and place	e, and d ue	to the ca	ause(s) and mann	er stated.
	within To the		29b. Signature and title of certifier	e Practioner: To the be	oat of filly h	niowieuge, de		icense i		ани ріасе	, and que to th				Day, Year)	
	P		1/1/ Jun	2	>		D	70	010	2		10-	-17-	-20	11	
			30. Name and add softperson who co													
	Charl		Ivan Zama, MD 31. Date filed (Month, Day, Year)	9200 Bas				arg	jo,Ml	D 20	774					
	Stat Registra		OCT 2 1 2011	A Hegistrar	3 Oignardi	re par										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Helen LIPTZ 5:25 P 2011 October 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bethesda Montgomery Suburban Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Ine 28 1 M 2 X F Months Director Pennsylvania 188-18-4672 88 June Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 No Maryland Montgomery Rockville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 1801 E. Jefferson Street #T-24 20852 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: r than "natural", the Medical Exa 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Jewish Community Center Elementary/Seconday (0-12) College (1-4 or 5+) <u>of Pittsburgh. PA</u> <u>Secretary</u> Be event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hi Important: If item 27 is marked ott any injury or other traumatic even ည Harry Feldman Dora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marci Harris-Blumenthal, Grandbaughter 506 Sheila St., Gaithersburg, MD 20878 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of 10/19/11 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Garden of Remembrance Memorial Park Clarksburg, MD Torchinsky Hebrew Funeral Home 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonary Fibrosis Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectonic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 5 Other (specify) Pregnant at time of death signed by the aid P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Vital Records, 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No has certificate • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Division of 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide npleted filled in by determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 17, 2011 D 0063195

State Registrar

5:25

20814

Steven Wilks, M.D., 8600 Old Georgetown Road, Bethesda, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 0 2011

31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		4	_ State	te of Maryland		rtment of tificate of			/ / / /	1 35331
		_	Registrar 1. Decedent's Name (First, Middle, Last)		Cert	incate of	Deali	2. Date of Death		3. Time of Death
	Physicia: Medic	al _	LETITIA McGREGOR	LINTHICUM				October		8:4/ AW
	Examin	_	4a. Facility Name (if not institution, give street an Shady Grove Adventist			4b. City, Town, Rocky	or Location of Deat 7 111e	n	4c. County of De Montgo	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last b		If Under 1 Year Months Day				irthplace (State or Foreign Scotland
	Director	-	579-20-2712	XF 88	Yrs.			reb. 26	,1743	
	yland f show	ctor	10a. State 10b. County	10c. City, To	own or Loc					10d. Inside City Limits 1 1 Yes 2 □ No
	ne Mar	ā	Maryland Montgomery 10e. Street and Number	Gal	rener	10f. Zip Code		1	Og. Citizen of What (
	s 23a c ust be	Funeral	419 Russell Ave. Apt.	415			20877		United Sta	
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatht and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.	þ	1 Never Married 2 Married 1 If You	s Decedent Ever in U.S. led Forces? Yes 2 X No les, Give or or Dates.	If	/as Decedent of Yes, specify Cu ☐ Yes 2 💢 N	Hispanic Origin? (S ban, Mexican, Puer No Specify:	pecify Yes or No- to Rican, etc.)	Black, Wh	nerican Indian, nite, etc. White
2-0	72 hour "natu edical	Completed	15. Decedent's Education (Specify only highest grade com	oleted)	(Give k	ent's Usual Occ ind of work don	e during most of wo	rking	16b. Kind of Busines	ss Industry
212	within i giene. er than the Mi		Elementary/Seconday (0-12) Coll	ege (1-4 or 5+)		NOT use retire			Own Home	
land;	is be filed v dental Hyg rked othe tic event,	To Be	17. Father's Name (First, Middle, Last) Alexander McGregor					me (First, Middle, M a Deans	Maiden Surname)	
Mary	d 2 should alth and M		19a. Informant's Name/Relationship (Type, Print) J. David Linthicum (19b. Mailin 3889	g Address (Stre Rust H	et and Number or R ill Place	ural Route Number, , Fairfax	City or Town, State, VA 2203	Zip Code)
Baltimore, Maryland 21215-0036	Page 1 and nent of Heis int: If item iny or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify)	of from State Cemi	etery, crem	sition (Name of natory or other p Mem • Pk	olace) Oct	Date 22, 011	20c. Location - City Rockville	
Balti	permit. F Departm Importa any inju	1	21. Signature of Funeral Service Licensee	(M0116)	22 1	Name and Add	lress of Facility De Deer Park	Vol Fune Dr. Gait	ral Home thersburg	MD 20877
	the state of		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Immediate Cause (Final	e on each line.			ying, such as cardia	c or respiratory arre	est,	Approximate interval Between Onset and Death Hour
المسعيب	Medical Examiner		3	yocardial In Oue to (or as a consequen		CIOII				
	- Adminici	iner	Sequentially list conditions, bb	Due to (or as a consequen	ice of):					
	and Trasit	Examiner	Cause (Disease or iinjury	Due to (or as a consequen	ice of):					
0	be ext	dical E	A							
8760	tificate ng phy. as the	Medi	IF FEMALE:					-		
P.O. Box 687	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial transition by the funeral director, page 2 should be detached for use as the burial transition.	Physician/Me	23b. Was decedent pregnant 1 in the past 12 months?	es, outcome of pregnancy Live Birth 2 Fetal d Pregnant at time of dea Unknown	leath 3 📙	Ectopic pregn Other (specify			23d. Date of Month	delivery Day Year
s, P.O.	ires that the signed by dibe detact	þ	Part II. Other significant conditions contributions	ng to death but not resulti	ing in the u	underlying cause	given in Part I.			e to the cause of death? ☐ Probably 4 ሺ Unknown
Division of Vital Records,	The law requisate has been page 2 shoul	Completed			<u>.</u>			24a. Was a autop perfor	prior rmed? prior deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
talF	sician: The certificate I irector, pagi	BeC	25. Was case referred to medical examiner?	1.			i. Place of Death (Ch Other:			
of Vi	ing Physia I. After this c uneral dire	ate: To	1 L Yes 2 X No	1 Inpatient 2 X EF	R/Outpatier 8b. Time of injury	f 28c. I	4 Nursing		dence 6 Other (S low injury occurred	pecify)
ivisior	or Attend after death Director: A in by the f	Certificate	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home building, etc. (Specify)	e, farm, str			28f. Location (S City or Tow	Street and Number or vn, State)	Rural Route Number,
Õ	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical (the bacic of exemination a	nd/or inves	tigation in my o	pinion, death occurre	ed at the time, date a	ing place, and due to	the cause(s) and mainter stated
	To the within 2 To the Complete	Ž	only one) 3 L Certifying Nurse Prace 29b. Signature and title of certifier	noner: To the best of my k	i iowiedge,	29c. Lic	ense number 20148		29d. Date signed (M October	onth, Day, Year)
	10		- Mal)	h					Jeeober	
			30. Name and address of person who completed Dr. Steven H. Dolins		3a) (Type, l	ssell A	ve. Gaith	ersburg,	MD 20877	
	Sta Registi		31. Date filed (Month, Day, Year) OCT 2 0 2011	22. Registrar's Signatur	hay	w				

DHMH 17 Rev 7/2009

11-07884 Bryan N Little

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1- For Stata Registrar Certificate of Death Reg. No.
Physici		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Medical Exami	ner	Bryan N. Little Month October 20, 2011 Year 0825 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
		Carroll Hospital Center Westminster Carroll
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or
Director		577-15-4495 1 M 2 F 27 Yrs. Months Days Hours Min. Nov. 4, 1983 Foreign Country) DC
		Usual Residence of Decedent
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once,	tor	Maryland Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
ne Mau or 28	Director	802 Sero Pine Lane 20744 United States
0036 within 72 hours after death with the Maryland jene. her than "natural", or items 23a or 28a-f sho Medisal Examiner must be notified at once.	ral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,
death or item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc.
ral", o	by F	3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: Specify: Black
5-0036 led within 72 hours afte Hygiene. I other than "natural", the Medical Examiner		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry
36 hin 72 than	Completed	2 Unemployed none
5-06 iled wit Hygien I other	Con	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
21215-0036 suld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Paul Little Sr. Yvette M. Duvall
ID 2 should and M 77 is m.	T _o	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yvette M. Duvall Little- Mother 802 Sero Pine Lane Fort Washington, Md. 20744
≥ da da Maria		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State
Baltimore, oermit. Pages 1 a Department of He mportant: If ite niury or other tr		1 🗵 Burial 2 Cremation 3 Removal from State crematory or other place) Nov. 4,
Baltimorr permit. Pages 1 Department of 1 Important: If injury or other		4 Donation 5 Other Specify: Heritage Memorial 2011 Waldorf, Maryland 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc.
Dep Der Q		Thu T- Stawart 2 4001 Benning Road NE Washington, DC 20019
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and
₹/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Death Death
		h
	ner	frany, leading to immediate Due to (or as a consequence of):
1,5	Examiner	(U)sease or injury that initiated events resulting in death) Last Due to (or as a consequence of):
760, foate be executed physician and the burial - transit		d.
be exe	Medical	X UNPENDED 23a,pt.II,27,per me,g925 3-15-12 sm
3760, ficate be g physic s the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day Year
Box 687 e death certific the attending	iciai	past 12 months?
Box 687 The death certification is the attending property of the atte	Physician/	1 Yes 2 No 9 Unknown 9 Unknown
ires that the signed by	by F	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
	ted	COTORIC ODSCIUCTION, TOTYCYSTIC KINNEY DISCUSC, 24a Was an 124h Ware autoney findings available
COFC law re has be	Completed	Schizophrenia autopsy prior to completion of cause of performed?
tal Reco cian: The law certificate has	_	25. Was case referred to medical 26.Place of Death (Check only one)
Vital ysician: his certifi director,	o Be	examiner? 1 ✓ Yes 2 No No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other: Nursing Home 5 Residence 6 Other:
1 of Vi ling Physi After this funeral dir	-	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred
ion ttendii leath. tor: /	atio	1 Natural 5 Pending 2 Accident Investigation 1 Yes 2 No
Division of Vital Records, rate or Attending Physician: The law requir is after death. *I Director: After this certificate has been sited in by the finneral director, page 2 should be a poor of the finneral director, page 2 should be a poor of the finneral director, page 2 should be a poor of the finneral director, page 2 should be a poor of the finneral director, page 2 should be a poor of the finneral director.	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City or Town, State)
E 6 P		4 Homicide Copenity
To the Howithin 24 h	Medical	224. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
7. W	Σ	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		O.C.M.E. October 21, 2011
CR	1	Associated address of person who completed cause of death (Item 28a)
_	ata	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Mopth, Day Year) 32. Register's Significant Signifi
St Regist		31. Date filed (Mopth, Day, Year) 132. Registrar's Signature 132. Registrar's Signature 133. Date filed (Mopth, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 35333 State Registrar amendeditem#26-wchd-te-10/12dentificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph Willard Layfield October 7, 2011 12:00 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 32329 Spearin Road Salisbury Wicomico . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Days Min (Month, Day, Year) **Director** 719-14-1675 1 **X** M 2 \square F 91 12/03/1919 Maryland Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 32329 Spearin Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 🔀 Yes 2 🗌 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Year or Dates. Army injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 | h and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4 or 5+) Agriculture <u>Farmer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Laudie James Claudis Layfield Grace (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 Pete Layfield/Son 32329 Spearin Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State Salisbury Crematory 4 Donation 5 Other (Specify) 10/10/2011 Salisbury, MD Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee Kelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ 115868R Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): death certificate be executed attending physician and for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform funeral director, of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes မ 4 Nursing Home 5 X Residence 6 Other (Specify) TZ impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of Injury at 28d. Describe how injury occurred Natural 2 To the Hospital or Attending 5 Pending work Division 1 Yes 2 No eral Director: A filled in by the f Accident

Accident

Suicide

Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 2 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35334 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201^{Year} October 14, 5:30 Рм Patsy Lee Morgan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick College View Center Frederick 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 1 □ M 2 🛣 F June 28 Maryland 219-44-3556 1947 **Director** Yrs 64 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 X No Maryland Frederick Thurmont 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral United States 21788 13701 Graceham Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. "natural", or items important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Caregiver Health Care 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mabel Virginia Boone William L. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $8110\ C\ Old\ Kiln\ Rd.,\ Thurmont,\ MD\ 21788$ William Morgan / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemptery organization of their place) 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorial Gardens 2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Se vice Licenses 22. Name and Address of Facility Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. Skkot Cody Frederick, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or har failure. List only the cause on each line.

Immediate Cause (Final disease or andition resulting in death)

a. Due to (or as a consequence of): Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or impury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Dav Year 9 Unknowr ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I þ Division of Vital Records, No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has t performed 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes Certificate: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours atter uccur...

To the Funeral Director: After 1 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year,

State Registrar Registrar's Signature,

Tohnson DV.

Frederick MB

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah

11-07794 Richard J Mueller

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			- For State Registrar		•	Ce	rtifica	te of	Death	'n			Re	g. No.		
Phys		n/	 Decedent's Name (First 										Date of Deatl Month	Day \	Year	3. Time of Death
Medical Exa	mir		Richard	John	Muller			1.0					October 17		ty of Deat	0923 hrs
			4a. Facility Name (if not i 2100 Lackawani	_	street and num	ber)		44	Adelpl		ocation of	Death			e Georg	
Funer			Social Security Number	er 6. Sex	× 7	. Age (In yrs.		day)		r 1 Year	If Under Hours	1.650			Forei	rthplace (State or gn
Direct	or	1	577-32-5870	1[X]	M 2 F	8	33	Yrs.	Months	Days	Hours	Min.	April 2	26, 192	.8 c	ountry) D.C.
	П	ļ	Usual Residence of Dece			10a Cit.	. Taum 0	r Locatio								10d. Inside City Limits
w any		-		P.G.		Toc. City		ttsv								1 Yes 2 X No
Aaryland 28a-f show	once	إذ		1.6.			пуа		10f. Zip				110	og. Citizen of	What Cou	
MOVE, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f shu	must be notified at once.	Director	10e. Street and Number 2100 Lacka	wanna	Street					0783				USA	VVIII OU	,
with th	pe not	- 1	11. Marital Status		12. Was Dece		J.S.		Deceder	nt of Hisp			ify Yes or No-		ace - Ame	rican Indian, Black,
death or iter	must	Funeral	1 Never Married 2	_	Armed For 1 Yes	2 No		_				- deito Kit	can, etc.)		,Whit	Α .
s after	niner	2	3 Widowed 4		If Yes, Give Year or Dates:	acompleted)	1460 D		Yes 2		specify: on (Give ki	nd of wor	k done	16b. Kind of	<u> </u>	
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21215-0036 buld be filed within 7 Mental Hygiene.	ent, t	å	John Richa										Victo			
ID 21215-003 should be filed within and Mental Hygiene.	utic es	ို	19a. Informant's Name/R		•		307						al Route Num			
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Ore, esla of He If ite	lber t		1 Burial 2 Cr	_	Removal from	n State	cremato	ry or othe	er place)		-		ot. 21	ŀ		
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	0 10	1		Other Specify:		Met	trope	olita					011	Alexa		
Baltimo permit. Page Department o Important:	il.	- [21. Signature of Funeral	Servica Licens	See O			Fra	inc1s	iver:	Coll:	ins l	Funera	1 Home Silver	Inc	ing, MD 20901
Physicia	_	\dashv	23a. Part Enter the disc			used the death	n. Do not									Approximate Interval
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760, icate be	e buri	Medical	IF FEMALE:		23c. If yes, or	utcome of pre	gnancy							23d. Date	e of delive	ry
687 ertific ding p	e as th		23b. Was decedent pregr past 12 months?	ant in the	1 Live bir		2	=	al death		Ectopic	pregnanc	у	Monti	1	Day Year
Box 68's death certifi	detached for use as t	Physician	1 Yes 2 No 9	Unknown	9 Unknov	nt at time of d vn	eath 5	Oth	er (Spec	cify)						
O. El tribe d	ached	튑	Part II. Other significant	t conditions			resulting	in the ur	nderlying	cause g	iven in Parl	t I.	23e. Did to	bacco use co	ontribute t	o the cause of death?
P.O.	l be deta	Completed by				_							1 Yes	2 No	3 Pr	obably 4 🗸 Unknown
requir	plnous	ete											24a. Was autop			autopsy findings available completion of cause of
e law	7	립												rmed?	death?	
tal Recol	or, pa		25. Was case referred to	medical						26.Place	of Death (0	Check on				
Vita hysicia this cer	:€	o Be	examiner? 1 ✓ Yes 2	No H	lospital: 1 In	patient 2	ER/Qu	tpatient	3 D	OA	Other ₄	Nursing !	Home 5	Residence	6 🗸 Oth	er: Scene
l Of ing Ph	ıneral	-1	27. Manner of Death	_	28a. Date o	f Injury Day,Year)	28b. T	ime of In	jury 2	_	y at Work?	- 1	3d. Describe	how injury oc	curred	_
ion trendi	the fi	턃	1 ✓ Natural 5 2 Accident	Pending Investigation	on L	-27-					'es 2 I					
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certify within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending.	d in by	Certification:	3 Suicide 6	Could not be	28e. Place	of Injury - At I	home, fai	rm, street	, factory,	, office b	uilding, etc.	. 28	Bf. Location (S or Town, S		imber or F	Rural Route Number, City
ospita hours	y fille	3	4 Homicide 29a. Certifier		an: To the best	of my knowled	dan dan	th occurr	ad at the	time da	te and plac	e and di	ie to the caus	e(s) and mar	ner as st	ated
the H thin 24	nplete	Medica	(Check only one) 1 Certification Certificati	ical Examiner	On the basis of	examination	and/or in	vestigati	on, in my	opinion	, death occ	urred at t	he time, date	and place, ar	nd due to	the cause(s)
	CO	ĕ	29b. Signature and title o	of certifier	and manner sta	ated.			290	. Licens	e number			29d. Date s	signed (M	lonth, Day, Year)
12	1		anes	2'						O.C.I	И.Ε.			October	18, 20	11
-		ŀ	30. Name and address o		•											
			Ana Rubio MD.	Assistar	nt Medical E	xaminer	900 W	/. Baltir	more S	Street,	Baltimor	e, MD	21223			
Box	St	ate rar	31. Date filed (Month, Pa	2011	32. Reg	jistrar's Signa	ture	ule								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar AMEND#20perFH, 10/26/11; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17, 1:14 A^M **October** 2011 Francis Xavier Monteiro 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore City Maryland General **Baltimore** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) Year) Days Months 214-47-4045 India 1966 44 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Maryland Montgomery Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7645 Laytonia Drive 20877 India 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify. Specify: Asian Indian 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Chef Food 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rosa unknown Augustine Monteiro 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Josethina Monteiro, Sister-in-law 19705 Boxberry Drive, Gaithersburg, MD 20879 Date 10/24/2011 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/21/2011 Alexandria, Virginia Metropolitan Crematory: 21. Signature Funeral Service Licenses 22. Name and Address of Facility Simple Tribute M01102 1040 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Arrhythmia disease or condition resulting in death)

Physician /Medical Examiner

permit. Pages 1 and 2 Department of Health Important: If item 27 eny Injury or other tra once.

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

Be

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or other traumatic event, Ire Medical Examiner must be notified at ury or other traumatic event, Ire Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner attending physician for use as the buria sate has been signed by the page 2 should be detached director, Certification: To n 24 hours after death.

Ne Funeral Director: Af bletely filled in by the fur

To the Hospital or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

After this

within 24 hor To the Fune

	Due to (of as a consequence of).				
Sequentially list conditions,	bCardiomyopathy				
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): c Due to (or as a consequence of): d				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	1	23d. Date of delive Month	ery Day	Year
Part II. Other significant condition Diabetes Melli	ons contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco u		he cause o	
		24a. Was an autopsy performed?	24b. Were auto prior to co death? 1 □ Yes	mpletion of	s available cause of

25. Was case referred to medical examiner?

1X Yes 2 □ No

27. Manner of Death

1 X Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

October 18, 2011

29b. Signature and title of cert

6 □Could not be

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gul C. Chablani, 11119 Rockville Pike, Rockville, Maryland 20852

State Registrar

Medical

31. Date filed (Month, Day, Year)

OCT 21 2011

and manner stated.

D42518

11-07345 Otha Mason

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	2	0	-		3	5	3	3
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		1- For State Registrar		Certificate (of Death		Re	g. No.	
Physic Medical Exam		Decedent's Name (First, Middle, LOTha L. Mason					2. Date of Deat Month Septembe		3. Time of Death 1447 hrs
		4a. Facility Name (if not institution,			4b. City, Town,	or Location of [4c. County of Dea	
		500 Maple Street Apt 12			Snow Hill			Worcester	
Funeral Director		, and the second	Sex 7. Age (In X) M 2 F 62	yrs. last birthday)		ear If Under 2 ays Hours	Min. 4 – 15 – 1	h(MM/DD/YYYY) 9. E Fore	Birthplace (State or eign CountryMD
		Usual Residence of Decedent	21M 2 F 02	r	rs.		4-13-	1949	
w any		10a. State 10b. County		City, Town or Loc					10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show d.at ooce.	cto	MD Worces 10e. Street and Number	ter Sr	now Hil	10f. Zip Code	-	110	g. Citizen of What Co	
the Ma	Director	500 Maple Str	eet. Ant 12)	21863			JSA	
21215-0036 Mold be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho t eveot, the Medical Examboer must be notified at ooce	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13. V		lispanic Origin	? (Specify Yes or No-		erican Indian, Black,
er deat , or ito	-	1 Never Married 2 Marri 3 Widowed 4 Divorce	ed If Yes 2 X ed If Yes, Give Year	No	Yes 2 X N		derto (vicari, etc.)	Blac	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examloer	d by	15. Decedent's Education (Specify	or Dates:	d) 16a. Decede	ent's Usual Occup	ation (Give kin		16b. Kind of Busines	
16 n 72 ho nan "na ical Ea	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		most of working lif	fe. DO NOT us	e retired)	G - 1 C - T	2 7
15-003 iled withi Hygiene. d other th	mo	10 17. Father's Name (First, Middle, La	st)	Carpe	enter	18.Mother's N	Name (First, Middle, M	Self-Emp	отоуеа
MD 21215-0036 d 2 should be filed within 7 lth and Mental Hygiene. n 27 is marked other than numatic eveot, the Medica	Be	Willie L. Mas	on			Ethel	Collins	5	
D 21 should and Me	ဥ	19a. Informant's Name/Relationship							tte, Zip Code) 21851
imore, MD 2121 Pages I and 2 should be fi nent of Health and Mental I sant: If iten 27 is marked or other traumatic eveot,		Beatrice Frye 20a Method of Disposition	2	Ob. Place of Dispo	osition (Name of c		Date POC	20c. Location - City	
MOF Pages 1 ent of 1 nt: If		1 X Burial 2 Cremation :		crematory or o		Com 1	10_8_2011	Stockto	on. MD
Baltimore, permit. Pages I an Department of Hea Important: If iter injury or other tra	1	21. Signature of Funeral Service Lic	en ee	22. R	Name and Addre	ss of Facility of	917 W. Is	sabella S	St.
	0	23a. Part I. Enter the disease, or con	nolications that caused the d	İFı	ineral	Home S	Salisbury	7. MD 218	Approximate Interval
Physician /Medical		failure. List only one cause on	eachline. a. Diabetic Ke t			g, 5 44 1 ab 5414	ado or roophatory arro	or, shoot, or rount	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequen						
	Je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequen	ce of):		···			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a consequen	ce of).					-
ecuted and transit		events resulting in death) Last	d.						
ਲ ਜ਼ਾਜ਼	Medical	■ UNPENDED	AMENDED 23a, pt	:.II,27, _F	er me,g	921 11-	8-11 sm		
18760, tificate be ng physicias the buri		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	_	etal death 3	Ectopic pr	egnancy	23d. Date of delive Month	ery Day Year
Box 68 death certificate attending	Physician	past 12 months?	Pregnant at time o	of do oth	Other (Specify)				
b.O. Bothat the dedetached f		Part II. Other significant conditions		not resulting in the	underlying cause	given in Part I	23e. Did tol	pacco use contribute t	to the cause of death?
- s 20 o	d by	Hypertensive A	theroscleroti	c Cardio	vascular	Diseas	se 1 ✓ Yes	2 No 3 Pr	obably 4 Unknown
Division of Vital Records, tall or Atteeding Physiciae: The law requirers after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be to be the funeral director, page 2 should be the funeral director.	Completed	Renal Failure;	Chronic Alco	hol Use			24a. Was a autops	y prior to	autopsy findings available completion of cause of
tal Rec	Son						perform 1 ✓ Yes 2		
/ital raiciao: is certifi lirector,	Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	ER/Outpatier		of Death (Ch		Residence 6 🗹 Oth	er: Scene
of \langle ing Phy After the funeral of	n: To	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of		ury at Work?		ow injury occurred	
Sion Vitteodi death. ctor:	atio	1 Natural 5 Pending 2 Accident Investiga	ition			Yes 2 No			
Division of pital or of pours after or after of filled in b	Certification:	3 Suicide 6 Could no determin		At home, farm, stre	eet, factory, office	building, etc.	28f. Location (S or Town, St		Rural Route Number, City
Division To the Hospital or Atteod within 24 hours after death To the Fuoeral Director:	S	29a Certifier	clan: To the best of my know	vledge, death occu	urred at the time, of	date and place,	and due to the cause	(s) and manner as sta	ated.
To the Howithin 24 h To the Fue	ledical		er: On the basis of examination and manner stated.	on and/or investiga			red at the time, date a		
	Σ	29b. Signature and title of certifier	50/11	4680	29c. Licen	se number		October 1, 201	
	ŀ	30. Name and address of person who	completed cause of death (Item 23a)					
			Assistant Medical Exa		V. Baltimore \$	Street, Balti	imore, MD 2122	3	
St Regist		31. Date filed (Month, Day, Year)	3. Registrar's Sig	nature day	w				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Joseph Matthews 13:11 PM 2011 Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's Washington Adventist Hospital Takoma Park If Under 1 Year 7. Age (In vrs. last birthdav) If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months (Month, Day, Days Hours 78 579-15-6446 Director Usual Residence of Decedent 28a-f shov or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20032 710 Congress Street Southeast United States hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 IV Yes 2 □ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced 4 Divorced Specify: Completed **Black** 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mec within 72 Elementary/Seconday (0-12) College (1-4 or 5+ DC Government Counselor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Lucille Whalen Joseph Matthews 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomasine Matthews/ Wife 710 Congress Street Southeast, Wash., DC 20032 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 💹 Burial 2 🗆 Cremation 3 🗆 Bernoval from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specif 10/21/2011 Tri-Angle, Virginia Quantico Cemetery Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P.A. MUIVES 5538 Marlboro Pike, Forestville, MD 20746 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part 1. Enter the disease, shock, or heart failure. List Approximate Interval Between Immediate Cause (Final Onset and Death Sis 2 0 Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed this certificate 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ျှ ER/Outpatient 3 DOA 1 Impatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 00060100

Registrar DHMH 17 Rev 7/2009

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State

Silve Ing

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BLVD East

32. Redistrar's

University

31. Date filed (Month, Day, Year)
OCT 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35339 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Victoria Babyjola During Mason **October** 14, 2011 12:25 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Prince Georges** 257 Harry S. Truman Drive; Apt. 32 Largo 9. Birthplace (State or Foreign Country West Africa Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1934 **Funeral** 1 □ M 2 **X** F Days Hours 76 219-77-8166 Director December 19, Sierra Leone Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 X Yes 2 No Maryland Prince Georges Largo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 20774 257 Harry S. Truman Drive; Apt. 32 Sierra Leone, West Africa death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Examiner Black, White, etc ò δ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.

The 1st filem 27 is marked other than "natural", or or other traumatic event, the Medical Examiury or other traumatic event, the Medical Examiury. Yes 2X No 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. **Black** Specify Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) Business Establishment Proprietress years Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ During Mary Cassell Edward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20774 Deidhra Peter-Thomas (Daughter) 257 Harry S. Truman Drive; Apt. 32; Largo, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State West Department of H Important: If ite any injury or otl Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Oct.29, Kissy Cemetery Sierra Leone, Africa 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Lo 22. Name and Address of Facility R. N. Horton Company Morticians, Lands Inc.;600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, cause. Enter Underlying Exami attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the death certificate be Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death detached 9 Unknown P.O. signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Hyperlipidemia Records, 1 Yes 2X No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 🗆 Yes 2 🗶 No Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No __ Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29c. License number 29d. Date signed (Month, Day, Year) D0055539 19, 2011 **October** MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Walker Mill Health Center Eugene Taylor, M.D. 1458 Addison Road South; Capitol Heights, Maryland 20743

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year, OCT 2 0 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35340 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death 13^{pay} 2011 Year Month 10 Physician/ 21:00 M Chalmon McKoy Richard Medical 4c. County of Death 4b. City, Town, or Location of Death a. Facility Name (if not institution, give street and number) Examiner Takoma Park Montgomery Washington Adventist Hospital Birthplace (State or Foreign Country)
 NC If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) Funeral 10 18 Days Hours 1 🛣 M 2 🗆 1935 NC **Director** 240-48-5990 75 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County within 72 hours after death with the Maryland Director 1X☐ Yes 2☐ No Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 20783 USA 837 Cox Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 15 Yes 2 No If Yes, Give 1968 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black 1968 3 Widowed 4 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Metro Station Manager Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Love1v Massy Charles McKoy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 837 Cox Avenue Hyattsville, MD 20783 Vertilue McKoy/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Wesley Chapel Cemete: 10/22/2011 Lillington, NC 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall-March Funeral Home 21. Sign ture of Funeral Service Licer 4217 9th St. NW, Washington, DC 20011 234. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to firm edite Examine cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death Year in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 No the s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗆 Yes Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed cate has page 2 s 1 Yes 2 No After this certificate funeral director, pag Yes 2 No 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 🗌 Yes 1. Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? ☐ Natural 5 Pending in 24 hours after co. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F only one) Dav. Year) 29d. Date signed (Month, 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Takoma Park, MD 20912 7600 Carroll Avenue Dr. Padma Chirumamilla, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State OCT 2 0 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35341 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death October Physician/ Alexander Miller 2011 1145 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Berlin Atlantic General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day,
NOV 17 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Country) Hours 1 🔀 M 2 🗆 F Davs Nov 216-56-1533 58 Director Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Worcester Ocean City 1X Yes 2 No MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21842 423 Robin Drive, Apt. 104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc.
African þ 1 Never Married 2 X Married hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Souf Chef Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental Fis marked of permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Beatrice Mills John Henry Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 423 Robin Drive, Apt. 104, Ocean City, MD 21842 Bonnie Lou Miller/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 10/14/2011 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) New Bethel UMC Cem 21. Signature of Funeral Service Licenses Lewis N. Watson Funeral Home, PA lance 1618 West Rd., Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CZNCEN 10NG disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Examiner Due to (or as a consequence of): use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last the attending physician and Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 🗌 Yes 2 🗌 No this certificate 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 🛂 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA . Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred mpleted filled in by the funeral injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State 2011 Registrar

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DOB

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35342 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Donald Denwood Mariner 1347 1 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico formsula Regional medical center alisbur If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, Year) 218-30-0844 73 **Director** 1 🛛 M 2 🗌 F 12/28/1937 Maryland Usual Residence of Deced show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at rector 28a-f Maryland Wicomico 1 🗌 Yes 2 🔀 No Salisbury ۵ 10e Street and Number items 23a or ner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 1425 Toadvine Road 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ō þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", Specify: White Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Production Manager Poultry traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Harvey Weldon Mariner Alice Irene Dorsev Department of Health and Important litem 27 is n any in ury or other traumonce. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara L. Mariner/spouse 1425 Toadvine Rd., Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State wicomico Memorial*** 10/19/2011 Salisbury, MD 4 Donation 5 Other (Specify) Park No. Tread Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Pulmonory Medical **Examiner** aram Negative Sequentially list conditions, it are reading to increasing cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last o (or as a conseque e of): Exami or Attending Physician: The law requires that the death certificate be executed Due to (or as a c sequence of) attending physician I for use as the burial Physician/Medical AŊ Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performed? Yes 2 No death? certificate 2 🗌 No 1 🗌 Yes Division of Vital ector. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 1 🗌 Yes Other: Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28c. Injury at nours after death.

neral Director: After the filled in by the funera Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural Accident 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled i Medical 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VP 31. Date filed (Month, Day, Year) Registrar's Signature 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 24a per dr., g921, 11/16/2011dhb
Registrar

Reg. No. 35343 2. Date of Death 3. Time of Death Physician/ October 139 2011 5:50 Рм William Edward Moler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 124 Fairground Ave. Washington County Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** March 6,1938 215-36-7189 Maryland Director 73 1 X M 2 □ F Usual Residence of Decedent 28a-f show 10a. State Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r Funeral 124 Fairground Ave. 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent Ever in Control Armed Forces?

1 Xyes 2 No. 1962
If Yes, Give 1965 'natural", or iter dical Examiner Black White etc þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 Divorced er than "natur , the Medical I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bussiness Machine Co. Computer Analyst event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental H 27 is marked of ir traumatic ever ပ Sarah Elizabeth Wolf Moler William R. Moler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Cleveland Ave. Hagerstown, MD 21742 Diane Harris-friend Department of Health Important: If item 27 any injury or other troone. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 10-21-2011 4 Donation 5 Other (Specify) Hagerstown, MD 21. alun of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami burial-transi Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 After this certificate has autopsy performed? Yes 2 N 1 Yes 2 No al or Attending Physician: Ti s after death. Il Director: After this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? 2 2 **X**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Alatural work? 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Hospital Medical ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 00055991 LISCH 9 28a) (Type, Print)

State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) october 15, 2011 9:50 A Eileen P. O'Gorman 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Carroll County Long View Nursing Home Manchester Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 29, 5. Social Security Number 7. Age (In vrs. last birthday Days Hours Min Months 1 □ M 2 🖫 F Mass. 033-09-7009 91 1920 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 2X No Maryland Carroll County Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21074 113 Weaver Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married white 1 ☐ Yes 2 💢 No Specify 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) own home College (1-4or 5+) homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Evalina Blais Andrew A. Lahey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 113 Weaver LAne HAmpstead, Maryland 21074 Joseph R. O'Gorman / husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition oct. 18, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Carroll Cremation Hampstead, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility of Funeral Service Li Eline Funeral Home M01072 934 South Main Street Hampstead, Maryland 21074 www 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Examiner The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria the After this certificate has been signed by funeral director, page 2 should be detact or Attending Physician: within 24 hours after death

To the Funeral Director; A Hospital the

Examiner Physician/Medical þ Be Completed Certification: To

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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traumatic event, the Medical Examiner must be notified at

2 should be filed within 72 hours after death with in and Mental Hygiene.

is marked other than "natural", or items 23a or:

permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any Injury or other traum once.

Physician

/Medical

Baltimore, Maryland 21215-0036

ē WJL 5

State Registrar

Medical

5 Pending investigation

6 Could not be determined

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signaty e and title of certifier

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28a. Date of Injury (Month, Day, Year)

and manner stated.

Rd Westminster, MD 21157

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d, Describe how injury occurred

Year) 9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1059 Sharon Lee Oney Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICAMICO KEGIONAL Centes TENINSULA MEDICAL If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 🗓 F Director 222-40-7973 DE 56 -22-1955 ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2X No Wicomico Salisbury 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21801 USA 648 W. Main Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Page 1 and 2 should be filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No
If Yes, Give
Year or Dates. O. Completed by 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specif**Black** 3 Widowed 4 Divorced other traumatic event, the Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. other than " life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12 <u>Labore</u>r Domestic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mental Hy marked 2 Joseph Oney Emma Deshields and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health item 27 Cornelia Oney/Sister 106 E. Lehigh Avenue, Salisbury, MD 21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State Direct Cremation, 10-17-2011 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) Bennie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801 Service Lensee or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1 shock, or heart failure Immediate Cause (Final disease or condition resulting in death) Cerebellar Physician/ Medical **Examiner** 17 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury use as the burial-tran that initiated events resulting in death) Last attending physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
 Funeral Director: After this certificate has been signed by the attending physicial ethics of the properties of the physician in by the funeral director, page 2 should be detached for use as the but the funeral director. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy☐ Other (specify) ____ in the past 12 months? Day Month Year Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, 27. Manner of Death 28b. Time of 28c. Injury at work? 1
Yes 28d. Describe how injury occurred 1 Natural 2 Accident Year) injury 5 Pending 2 No Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2011 who completed cause of death (Item 23a) (Type, Print) 30. Name and addre HODOBTOOKE Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Donovan Leonard Palmer October 19 2011 7:30 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Dove House Westminster Carroll County 5. Social Security Number **Funeral** . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours 219-14-9394 Director 88 Sept. T923 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? Funeral 1172 Luther Dr. 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. or than "natural", or iter the Medical Examiner 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No Black. White, etc. Completed by 1 \square Never Married 2 \square Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation refiled with refailed with ref 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Sandblasting Equip. Elementary/Seconday (0-12) College (1-4 or 5+) Salesman should be filed with and Mental Hygien is marked other th Mfg. Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Waldo Palmer Ima Herbst Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Lisa McDowell-daughter permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 11788 Stonegate Lane Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State Rose Hill Cemetery 10/25/2011 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Douglas A. fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PIRATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence on sician and burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Ectopic pregnancy Pregnant at time of death Other (specify) Month Day Year g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' Yes Hospital or Attending Physician: 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 1.No Hospital: မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Division work 1 Tyes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 124 hours a Medical 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one 29b. Signature 29d. Date signed (Month, Day, Year) ess of person who completed cause of death (Item 23a) (Type, Print) ST- WESTMINSTER ND 21157 egistrar's Signatur Registrar

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		State Registrar	- /5: \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1			Ce	rtificat	te of E	Death	1		Reg. No.	201	3534
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Funeral		Brighton 5. Social Security No	umber	6. Sex		e (In yrs. la	st birthday)		r 1 Year	If Under 24 Hrs	. 8. 0	ate of Bird	th	9. Bir	thplace (State or Foreign
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d 2 should alth and N 27 is ma er trauma		19a. Informant's Na Bette Ja			•	er		-		and Number or Rule Lane				own, State, Zip D 2085	
bage 1 and sent of He nut: If item ry or other		20a. Method of Disp 1 Durial 2 4 Donation			al from State	, 0	lace of Disp emetery, cre	matory or	other plac	emet 10/2	Date 21/2	011		er Spr	Town, State ing, MD
permit. F Departm Importa any inju		21. Signature of Fu	-	ensee	1111	/	2	2. Name a	nd Addres	ss of FacilityJos	eph	Gaw	ler's	Sons	Inc.
Physician/ Medical Examiner		23a. Part 1. Enter t shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List or Final	a. Co	s that cause e on each lin erebro Due to (or as theros	e. Vascu a consequ	ılar A	ccide	ent	<u> </u>	c or res	piratory ar	rest,		Approximate Interval Between Onset and Death
and transit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death)	nmediate rlying iinjury s	b. —	Oue to (or as ortic Oue to (or as	a consequ Value	ence of):								
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial tractions.	Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 l 1 ☐ Yes 2 ☐ 9 ☐ Unknown	months? ☐ No	1 4 5	res, outcome Live Birth Pregnant	2 🗌 Feta	death 3	☐ Ectopic ☐ Other (s	pregnanc	гу			2	3d. Date of de Month	livery Day Year
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The law requate has been page 2 shou	Completed													prior to death?	itopsy findings available completion of cause of
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ing Phys	ate: To	27. Manner of Deati	5 Pending	28a	1 Inpat a. Date of injute (Month, Date)	iry	ER/Outpation 28b. Time of injury	of	28c. Injury work	/ at ?	1		dence 6 [now injury		cify)
al or Attend s after death Il Director: /	Certificate:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	Investig 6 Could n determi	ot be	. Place of In building, et			M treet, factor		Yes 2 □ No		Location (S City or Tov		Number or Ru	ral Route Number,
ne Hospit in 24 hour ne Funera pleted fille	Medical	(Check 2	☐ Medical Ex	caminer: On	the basis of	examination	and/or inve	stigation, in	n my opinio	, date and place, on, death occurred e time, date and p	at the t	ime, date a	and place, a	and due to the	cause(s) and manner stated
Vith with Com		29b. Signature and	title of certifier	jers	veo	15		29	D536					signed (Mont 1/2011	h, Day, Year)
		30. Name and addr Ajay Red	ldy Mp 3		ower (aks 1	Blvd.	#110		cville, l	MD 2	20852			
State Registra		31. Date filed (Mont		011	32. Registr	ar's Signa	ure A	Mad.							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ POOLE 3ctober 14 MILDRED VIRGINIA 1:26PM Medical ZOII 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death DOCTORS HOSPITAL LANHAM PRINCE GEORGE'S 5. Social Security Number **Funeral** . Age (In yrs. last birthday, If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours Min. JUNE 6 Director PENNSYLVANIA 223-30-1273 โว๊26 85 Usual Residence of Decedent 2/ is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits 1

Yes 2 □ No MD PRINCE GEORGE'S SPRINGDALE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 3617 COUSINS DRIVE 20774 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force: Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 X No If Yes, Give 1 ☐ Yes 2 X No Specify. BLACK 3 Widowed 4 Divorced Specify. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with of Health and Mental Hygien item 27 is marked other the 11th HOMEMAKER PRIVATE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 DAVID MARSHALL IRENE VIRGINIA MILLER 2000 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, BRENDA JARRETT/DGT. 3617 COUSINS DRIVE SPRINGDALE, MARYLAND 20774 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Cther (Specify) ARLINGTON CEMETERY 11/16/2011 ARLINGTON, VIRGINIA 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility Raphne 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, 1 complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 No 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 2 No 1 🗌 Yes Hospital or Attending Physician; npleted filled in by the funeral director. To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2. No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide Investigation 1 Yes 2 No 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the basis of my including death occurred at the time, date and place, and due to the cause(s) and in time as estated. (Check To the within 2 D64268 fame and address of person who completed cause of death (Item 23a) (Type, Print) 8118 Good Luckld., Lanham, MD. 201010 MDa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35349 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 17 Physician/ 2011 7:15 AM Niccolas F. Plater Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Chevy Chase HCR Manor Care 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number **Funeral** (Month, Day, July 23 Maryland 1 □ M 2 🖾 F Months Days Hours 94 **Director** 577-24-1360 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State Director 1 X Yes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 20019 5125 H Street SE . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 **Black** 1 ☐ Yes 2 No Specify. If Yes, Give Specify 3 ☐ Widowed 4 🖾 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private the Domestic Companion 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Avon Parran Pinkney Sewall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20019 Washington, DC 5125 H Street SE Doris E. Plater - Daughter permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 3 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 21, cemetery, crematory or other place) October 2011 ■ Burial 2 □ Cremation 3 □ Removal from State Suitland, Maryland Cedar Hill 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, 21. Signature of Fune al Service Licensee 4001 Benning Road NE Washington, DC 20019 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ Failure to Thrive disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Advanced Dementia Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical P.O. Box 68760 the use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year for Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Kunknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed' 1 🗌 Yes 2 🗌 No Yes 2 X N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 XNo ည 1 Inpatient 2 ER/Outpatient 3 DOA this : After this funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury 5 Pending Accident death. 1 🗌 Yes Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 20, 2011 D0054566 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 20902 Silver Spring, Md. Sunitha Bhogavilli MD 9801 Georgia Avenue, Suite 1-17 31. Date filed (Month, Day, State

Registrar

OCT 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 7:18 A M Gary Lynn REID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 🔀 M 2 🗆 F Months Hours Min Yrs Director 0klahoma 440-58-1140 Feb. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 👿 No Maryland Washington Myersville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 1 Funeral 4705 Ford Fields Road 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r iffe. DO NOT use retired)
Information Technology Elementary/Seconday (0-12) College (1-4 or 5+) 12 2 Professional Computers permit, Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If Item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Elliot Reid Carmelita Van Deventer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Kathy Reid - Wife</u> <u>4705 Ford Fields Road, Myersville, Md.</u> <u> 21773</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 10/26/2011 | Hagerstown, Maryland 22. Name and Address of Facility Minnich Funeral Home 21. Signature of Funeral Service Licenses E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Asystole disease or condition Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or finjury that initiated events resulting in death) Last and -tran Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | d be det ģ Colon Cancer 1 Yes 2 No 3 Probably 4 Yunknown Completed been si should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has l director, page 2 s performed 2 🗌 No 1 Ves 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes 2 1 No ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Matural 5 Pending work? 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: Afteleted filled in by the fun Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2

To the F

complet 3 [only on 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0058726 10-25-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

V. 14 H. Interpretation MD 3000-D Venture Ct. Myersuite MD 21773

Registrar

State

31. Date filed (Month,

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 10 1935 M Physician/ Day Year Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth g. Birthplace (State or Foreign If Under **Funeral** Days 1 XM 2 □ F Hours Min March^{ay}, 26, 1950 Maryland 212-56-4309 61 Director Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director Maryland Washington Hagerstown 1 XYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 673 Hayes Avenue 21740 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. the Medical Examiner Armed Forces?

1 Xes 2 No Black, White, etc. ò 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: white Specify "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) leather tannery Be Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ٩ Richard Roberts, Sr. Unknown Barbara Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Roberts - wife 673 Hayes Avenue, Hagerstown, Maryland 21740 Department of Health Important: If item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Hagerstown Crematory 1 Burial 2 XCremation 3 Removal from State Oct 2024 Hagerstown, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home any ale 415 East Wilson Blvd., Hagerstown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tailure Physician/ toute disease or condition resulting in death) Medical Due to for as a consequen Examiner Sequentially list conditions, if any, Isading to Immediate cause. Enter Underlying Cause (Disease or linjury that in the approximation) Examine signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by acid 0415 2 No 3 Probably 1 Yes enhopenka 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 death? 2 🗌 No Yes 2 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ပ္ 1 Yes 2 **I** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Mann r of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 | No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier è e of death (Item

State Registrar Date filed (Mont)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35352 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 10 Physician/ Year 11 Day21 Theresa Rizzutti 6:20 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Howard Columbia Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 Months Hours 55 M2 1 2 2 1 9 55 **Director** 220-72-1233 Usual Residence of Decedent 28a-f show 10a. State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Hampstead 1 Yes 2 No Carroll MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4016 Gill Ave 21074 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ ☐ Yes 2 ☐ 💢 o Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Art Fine Artist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Rizzutti ၉ Louise Krausman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau Joe Tabeling/husband 4016 Gill Ave Hampstead MD 21074 Baltimore, 20a. Method of Disposition 20b, Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗆 Burial 2 Cremation 3 🗆 Removal from State Hanover, MD 4 Donation 5 Other (Specify) Ardent Crem. Svc. 10/22/11 21. Sig ture of Funeral Service 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ RECTAL disease or condition EBRUARY 2009 Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) requires that the death certificate be executed nding physician and use as the burial-trar Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Records, 1 ☐ Yes 2 🗖 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law page 2 s autopsy performed 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 2 X No 1 Tes HOSPICE မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 X Natural 5 Pending work within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1. 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 064395 29d. Date signed (Month, Day, Year) OCTOBER 21, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044 6336 DANIELLE DOBERMANIMO

State

Registrar

31. Date filed (Month

acked

egistrar's Signature

DHMH 17 Rev 06-2011

State Registrar

Sarah Bromeland, MD

31. Date filed (Month, Day

Box 68760

P.O.

Records,

of Vital

1500 Forest Glen Road, Silver Spring, MD 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12.02PM Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Harwood **Examiner** Anne Arundel Mandrin House 7. Age (In yrs. last birthday) 82 yrs cial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-36-2048 1 1 2 F Days Hours Min Months Oct. 17, 1928 Maryland **Director** Usual Residence of Decedent 28a-f shov er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 □ No Maryland Prince George's College Park 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20740 3718 Marlbrough Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No
If Yes, Give 1950-1952 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status . Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 ▼No Specify Specify: White Completed 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. College (114 or45+) Elementary/Seconday (0-12) **PEPCO** Tax Accountant other traumatic event, Be 18. Mother's Name *(First, Middle, Maiden Surname)* Flora Sinclair Nelson 17. Father's Name (First, Middle, Last) and Mental F မ Randall Ravenscroft permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marked any injury or other traumatic e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3718 Marlbrough Way College Park, Maryland 20740 Loretta Ravenscroft -wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Fort Lincoln Cemetery 10/22/2011 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses Bonald V. Borgwardt Funeral Home, PA Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between set and Deat Immediate Cause (Final CARCINOMA UNKNOWN Physician/ disease or condition Medical resulting in death) ue to (or as a consequenc Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) n and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) ιΩ resulting in death) Last physician a Physician/Medical 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death n signed by the a Id be detached f Yes 2 No 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 2 🗌 No 1 🗌 Yes Yes Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending work? 1 🗌 Yes 2 🖵 No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check etifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, + 0 36. Name and address of person wh DEFENSE HWY, ANNAPOLIS, M.D. 2160 シア TIL rlok 31. Date filed (Month, Day, 32. Registrar's Sigrature State 0 2011 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35355 State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month Elfriede Maria Renner Medical October 2011 4:59 a.m[™] 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St. Mary's Callaway **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 💢 F Months Days Hours Director 08/22/193 096-44-3198 79 Czechoslovakia Jsual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits MD 1 Yes 2 X No St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40798 South 40 Drive 20650 United States death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 72 hours after al Hygiene. 2 X No If Yes, Give Year or Dates 3 Midowed 4 □ Divorced 1 ☐ Yes 2 X No Specify. Specify: Completed White injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manager/Owner Bakery and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Johann Scheinost Albina Sper1 Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Lorraine E. Boyle/Daughter 40798 South 40 Drive, Leonardtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Calverton Natl. Cem. 10/28/2011 | Calverton, NY 22. Name and Address of Facility Brinsfield Funeral Home, 21. Signature of Funeral Service Licensee Danielle Ward 101403 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ Aspiration Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Chronic Kidney Sequentially list conditions, Examine If any, leading to ininequate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of To the Hospital or Attanding Physician: The law requires that the death certificate be executed within 24 hours after death. and burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? After this certificate Yes 2 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No မ Other: Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Accident Investigation 1 Tes Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined building, etc. (Specify) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, due the control at the time date and place, and due to 29c. License number 29d. Date signed (Month. Day, Year) D0071807 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20) rome

Registrar DHMH 17 Rev 7/2009

State

Sarah Johnson,

31. Date filed (Month, Day, Year)

OCT 2 4 2011

40900 Merchants Lane, Leonardtown, Maryland 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene 201 State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 16 2011 Physician/ OCTOBER ALBERT REID Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 579-52-0535 Director 71 APRIL 1940 WASHINGTON.DC Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🕅 Yes 2 🗌 No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1922 PALMER PARK ROAD 20785 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No USA If Yes, Give Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 2 No USAF Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: BLACK 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday} \ \text{(0-12)} \\ 12TH \end{array}$ College (1-4 or 5+) BUS DRIVER GOVERNMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 NAMON REID GEORGIA MAE PEAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DEBORAH B. REID/WIFE PALMER PARK ROAD HYATTSVILLE MARYLAND 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHELTENHAM, MARYLAND VETERANS CEMETERY ! 10 - 24 - 11Signature of Funeral Service Licensee, J. B. JENKINS FUNERAL HOME, INC. 22. Name and Address of Facility 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final FATAL Physician/ CALDIAC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) signed by the attending physician and defeached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day Pregnant at time of death page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 ☐ Inpatient 2 KER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death. Director: After this 27. Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practionen To the b death procured at the time, date and place, and due to the name(s) and manner as stated 29b. Signature and title of certifi 30. Name and address of person ho completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE CHEVEKLY MD 3001 DAVIS GRIFFIN MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

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Oct. 29, 1 7. Age (In yrs. lacobirthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 F Months Days Hours New York 72 Director 096-30-8724 Usual Residence of Decedent show or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Delmar Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ō ?7 is marked other than "natural", or items 23a on traumatic event, the Medical Examiner must be Funeral U.S.A. 21875 8926 Rum Ridge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married 1 Tes 2 X No Specify: If Yes, Give Year or Dates Thomas Rabbi Baltimore, Maryland 21215-003 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Nursing Home Registered Nurse Be Page 1 and 2 should be filed ν πent of Health and Mental Hyg 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First Middle Last. 2 Mary Murphy Thomas Rabbitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Arlene Rabbitt (Wife) 8926 Rum Ridge Road Delmar, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ₺ Other (Specify) Entombment Dueen of All Saints Cem. 10-18-2011 | Central Islip, NY Short Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 3 East Grove Street Delmar, DE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE use 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy has Yes 2 certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 2 1 No ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature erson who completed cause of death (Item 23a) (Type, Print) 20TC 20 roduliu 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Robin Debr otables 1050A Medical 10 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Julia Mander Health Washington It aberestown 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
June 29, 1960 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex Funeral Months Days 1 M 2 K F Hours 217-58-3213 51 Mary land Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Washington Hagerstown 1X Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 602 Guilford Avenue 21740 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. white Specify Completed 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hospital director of safety other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname and Mental F Marguerite Kelso မ Russell U. Neff, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 21421 Ridenour Road, Boonsborg, Maryland Russell U. Neff, III - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Lawn Memorial
Park 1 X Burial 2 Cremation 3 Removal from State October 26, 2011 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service I 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ Perocressive Apvote disease or condition SPAUSE Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ate has been signed by the atte page 2 should be detached for in the past 12 months?
1 ☐ Yes 2 ☒ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Asthma, URINAM Retention, Chronic 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Seizure Disorder 24a. Was an Disease, autopsv performed? certificate 1 ☐ Yes 2 ☐ No 2 🗷 No Yes 25. Was case referred to medical Be completed filled in by the funeral director 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 X No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, Af 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 5 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R125360 who completed cause of death (Item 23a) (Type, Print) RNP-333 Mill Street, Hagerstown MD 21740

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Mon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 16, 2011 Ann Grace Sadick 825 PM M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Potomac Valley Nursing and Wellness Rockville Montgomery 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 Days Hours 0873771937 New York 261-54-4486 **Director** 74 Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shora marked other than "natural", or items 23a or 28a-f shora in marked other than Medical Examiner must be notified at or 28a-f shov 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits with the Maryla Montgomery Rockville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1716 Evelyn Drive 20852 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify White Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 Contract Specialist US Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irving Sperling Rose Aries 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1716 Evelyn Drive Rockville MD 20852 permit. Page 1 and 2 she Department of Heath an Important: If item 27 is any injury or other trau Eugene Sadick - husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place. Judean Memorial Gard. 10/19/2011 Olney, MD 4 Donation 5 Other (Specify) 21. Signature of Funere Service Licensee Danangky-60falberg Memorial Chapels Inc 1170 Rockville Pike Rockville MD 20852 M01163 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ erepro disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical the Hospital or Attending Physician; The law requires that the death certificate be ethin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent preg s, outcome of pregnancy Live Birth 2 Fetal death 23d. Date of delivery in the past 12 month 1 Yes 2 No 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) Pregnant at time of death Month Day Year 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 000 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes 3 Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of D th 28a. Date of injury 28b. Time of Certificate: 28c. Injury 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Accident Investigation the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) 10 Name and address of person who cou

State Registrar

20350

within 24 hours after death

To the Funeral Director:
completely filled in by the 1 the 2

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier answeiga, MD 051705

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. Westminster, Mn 21157 M. PANSURIYA 349 Malcolm

State Registra

31. Date filed (Month, Day, Year)
OCT 1 9

2011



WJL

Box 68760 Division of Vital Records, P.O.

Baltimore, Maryland 21215-0036

State Registrar

WJL 5+10 (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Staritz, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

park

2111 Harover Pike

32. Registrar's Signature

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D0060503 29d. Date signed (Month, Day, Year)

21074

		•	1 - State Registrar	olato ol mai yiani	Cert	ificate of L		F	Reg. No.						
	Physicia	ın/	1. Decedent's Name (First, Middle, L	•				2. Date of Dea	th	3. Time of Death					
1-10	Medic	al	Waldema 4a. Facility Name (if not institution, gi			# 60 T	- Land Const Donath	Monthob	1						
	Examin	er		morial Hospital			Location of Death Frederick		4c. County of Dea						
	Funeral Director			Sex 1 M 2 D F 7. Age (In yrs. Ia		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr 9	9. Bi	rthplace (State or Foreign ountry) ISSLa					
	and show	è	Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Loca	ation				10d. Inside City Limits					
	Maryla 28a-f otified	Director	Maryland Carro	11			Taneyto	wn		1 🎗 Yes 2 □ No					
	h with the ns 23a or nust be n	Funeral D	10e. Street and Number 156 Saddletop Dr	ive		10f. Zip Code	21787		10g. Citizen of What C						
9000	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 — Yes 2 No If Yes, Give Year or Dates.		as Decedent of Hi Yes, specify Cuba □ Yes 2 🗖 No	ispanic Origin? (Spo n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.					
15-(72 hou n "nat Medica	nple	15. Decedent's (Specify only highest	grade completed)	(Give kil		ation during most of work	ing	16b. Kind of Business	s Industry					
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/land	d be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Middle, Las. Alexander Ste	•			18. Mother's Nam	e (First, Middle, I ie Derza							
, Man	nd 2 shoul ealth and I n 27 Is ma ier trauma		19a. Informant's Name/Relationship Elizabeth M. Ste						City or Town, State, Z						
Baltimore, Maryland 21215-0036	Page 1 ar ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe	☐ Removal from State Ca:	lace of Disposi Octon crema rroll (ition (Name of atory or other plac Cremator y	^(e) 10/1	Date 7/2011	20c. Location - City o						
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Lice	Durboran	22.	Name and Addres	ss of Facility My ltimore S	ers-Durk t, Taney	ooraw Funer ytown, MD 2	cal Home 21787					
-	Physician/ Medical		83a. Part). Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that caused the death one cause on each line. a	,		g, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death					
Janes P	Examiner			Due to (or as a consequence of so						years					
	suted nd ransit	camine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a conseque	f bulla	カット				year,					
90	ificate be executed ng physician and as the burial-transit	dical Ex	dical E	dical E	Medical Examiner	dical Ex	dical Ex	resulting in death) Last	Due to (or as a consequence) d	ence of):	_				,
. Box 68760		Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnar 1 Live Birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnanc Other (spec <i>ify)</i>	y		23d. Date of d	elivery Day Year					
, P.O.	es that th igned by be detac	by	Part II. Other significant conditions	contributing to death but not resu	ulting in the und	derlying cause giv	en in Part I.		bacco use contribute t						
ords	require been s	leted						1 □ Y		Probably 4 Unknown utopsy findings available					
Reco	: The law icate has r, page 2 :	Completed		1				autop: perfor 1 🗌 Yes	sy prior to med? death?	completion of cause of					
Vita	rsiciar s certif	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 → No	Hospital:	ER/Outpatient		er:		ence 6 🗌 Other (Spe	offs)					
n of	iding Phy th. After this funeral o		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigati	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	/ at		ow injury occurred	City)					
Division of Vital Records,	tal or Atter rs after dea al Director ed in by the	Il Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 390 Blace of Injury At hor	me, farm, stree	t, factory, office		28f. Location (St City or Town	treet and Number or R n, State)	ural Route Number,					
	he Hospi iin 24 hou he Funer: ipleted fill.	Medical	(Check 2 <u></u> Medical Exa	nysician: To the best of my knowle miner: On the basis of examination urse Practioner: To the best of my	and/or investig	ation, in my opinic	n, death occurred a	t the time, date ar	nd place, and due to the	cause(s) and manner stated.					
	M2 with		29b. Signature and title of certifier	1 en u		29c. License	number も926	2	29d. Date signed (Mon						
			<u>₩</u>	·					-						
	Wg		30. Name and address of person who		23a) (Type, Prii フェン人	nt)	nck Ms	2170/							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death nonth bey Physician/ 00234 2011 Medical 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MICOMICO SA YISHU TENINSULA Birthplace (State or Foreign Country) If Under 1 If Under 24 Hrs Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 🗙 F Director 9 Oct. 7, 2011 Maryland 28a-f show 10d, Inside City Limits 10a State 10c. City, Town or Location Examiner must be notified at Director 1 X Yes 2 □ No DE Laure1 Sussex 10g. Citizen of What Country? 1Ωf. Zip Code 10e. Street and Number Funeral items 23a 19956 U.S.A. 169 Delaware Avenue death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. or þ 1 X Never Married 2 Married Page 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Yes, Gir Completed white 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) n None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Kathleen O'Dea Harvey Wayne Sprague, Jr. 19a. Informant's Name/Relationship (Type, Print) (father) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19956 169 Delaware Avenue Harvey Wayne Sprague, Jr. Laurel, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of Important; If it any injury or o 1 XBurial 2 Cremation 3 Removal from State Oct. 12, 2011 Delmar, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Melsons Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Short Funeral Home 13 East Grove Street Delmar, DE ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one complicate the complete shock is the complete shock. Immediate Cause (Final Extreme prematurity
Due to (or as a consequence of): Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death Other (specify) detached been signed by the should be detached Unknown il or Attending Physician: The law requires that the cather death.

Director: After this certificate has been signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 ☐ No 3 ☐ Probably 4 🖒 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? death? 1 Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) To Be 2 X No 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 5 Pending 1 Natural Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Hospital 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number D45036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth ex 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month / O Christine Day Marie Stegmaier 3 2011 37 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Coastal Hospice at Salisburg Wicomico Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F 300-46-0931 Days Hours Min Director 63 02/05/1948 Ohio Usual Residence of Decedent 28a-f show 10a. State 10b. County the Medical Examiner must be notified at 10c. City. Town or Location Director 10d. Inside City Limits Maryland Wicomico Salisbury 1X Yes 2 ☐ No 10e. Street and Number 23a or 10f. Zip Code 10g. Citizen of What Country? Funeral 403 Park Ave. 21801 USA items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 X No "natural", or 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Important: If item 27 is marked other than any injury or other traumatic event, the Marone. College (1-4 or 5+) Elementary/Seconday (0-12) Dietician Healthcare Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Robert X. Conly Patricia Marie Hensler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Stegmaier Jr/spouse 403 Park Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Salisbury Crematory 10/15/2011 Salisbury, MD 22. Name and Address of Facility
Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisburg, MD 21004 Signalur of Funeral Service Licensee Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last sate has been signed by the attending physician a page 2 should be detached for use as the burial-Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 menths? Month Pregnant at time of death 1 Yes 25 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 🛮 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 Yes 2 To 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence of Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation M 1 Yes 2 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bot 1733 Sty Buly up 21022 a Huyton 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 3 per dr., g921, 11/04/2011 dhb Certificate of Death 1 - State Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 22, Day 2011 ear OCT. Mary E. Skelly 6:45 pM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Allegany Golden Living Center Cumberland 8. Date of Birth
(Month, Day, Year)
Sept. 14,1921 If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 M 2 1 F Months Days Hours Min. Maryland Director Yrs 215-12-2246 90 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director notified 28a-f MD Allegany LaVale 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 5 10g. Citizen of What Country? ms 23a or must be r Funeral U.S.A. 103 West Street 21502 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give WWII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc. ŏ þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify White Specify: "natural" Completed 3 NVIdowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) the Geological Survey US Government 12 other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked of rother traumatic even ည Mary Edna (Kyne) Sheetz George F. Sheetz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Mary Croston Niece 17923 Kitty Carr Lane, Rawlings, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Ambrose Cemetery Oct. 25,2011 4 ☐ Donation 5 ☐ Other (Specify) Cresaptown, MD Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Ran 1. Enter the obstace, or complications that salesed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Hafer Funeral Service, P.A. 1302 National Hwy., LaVale, MD Approximate Interval Between Onset and Death Physician Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate to 24 hours after death.
Funeral Director, After this certificate has been signed by the attending phys IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy 2 No 1 Yes Division of Vital 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 ☑ No ဂ္ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Certifying Nurse Practioner: To the I within 2 only one) of certifier 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person death (Item 23a) (Type, Print) State NOV 0 4 201

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 24Day October 11:33A M Robert Thier 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 13914 Eden_Drive Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1**X** M 2 □ F Months 12/13/1922 Wisconsin **Director** 88 397**-**14-0342 Usual Residence of Decedent should be filed within 72 hours are... and Mental Hyglene.
I is marked other than "natural", or items 23a or 28a-f show if is marked other than "natural", or items 23a or 28a-f show if it went, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 13914 Eden Drive 21742 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 1f Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Engineering Structura1 Architectural 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic Charles Thier Hannah Sulzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Betty N. Thier / Spouse 13914 Eden Drive, Hagerstown, MD 21742 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place Smithsburg Crematory 10/26/2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Servi 22. Name and Address of Facility Rest Haven Funeral Chapel Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death h sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Examine Due to (or as a consequence or) and I-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a I for use as the burlal-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Pregnant at time of death 2 No Yes been signed by the should be detached Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Tes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an page 2 s has prior to completion of cause of death?

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To the Funeral Director: After this completed filled in by the funeral dir this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
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State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			31. Date filed (Month, Day Year						-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene **1 –** For State Registrar 35369 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 0850 4 M Physician/ Samuel Taylor, Jr. Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LAUSBUR ICAMICO TENINSULA KEGIONAL 9. Birthplace (State or Foreign 8. Date of Birth (In yrs. last birthday. **Funeral** Months (Month, Day, Year) 79 Director 218-24-5237 1 🔀 M 2 🗆 F March 18, 1932 Maryland ms 23a or 28a-f show must be notified at 10a. State 10h. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🏝 No Salisbury MD Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Funeral USA 21801 1001 Tuscola Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian ural", or iten I Examiner n Armed Forces?

1 X Yes 2 No
If Yes, Give 1951-1955
Year or Dates. Black, White, etc. þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: "natural", 3 Widowed 4 Divorced Black Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me life. DO NOT use retired) Occidental Chemical Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jessie Bertha Gale Samuel Robert Taylor, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1001 Tuscola Avenue - Salisbury, Maryland 21801 Yvonne Taylor/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other plac Fastern Shore Veteran Cemetery 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department or Important: If any injury or Oct. 18,11 Hurlock, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Salisbury, MD cel - 1213 Jersey Road 21801 Jolley Memorial Chapel -23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ MVOCATOIAL ZNATOIO disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or a a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending housing and page 2 should be detached for use as the burial-transit C.A.D. Due to (or as a consequence of resulting in death) Last CARSIOMYOPATA Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Pregnant at time of death Unknown Month Day 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eral Director: After this certificate has filled in by the funeral director, page 2: performed 1 🗌 Yes 2 🔲 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 [] 3 [] Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10/13/11 142522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35370 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Walter F. Thompson 230 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico If Under ma. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F 08/16/1946 237-76-3640 Months Days Hours Min. North Carolina **Director** 65 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Wicomico 1 🗌 Yes 2 🔀 No Parsonsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33388 Bob Smith Road 21849 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

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Parsons Cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 10/15/2011 Salisbury, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licen Hoffoway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cape hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Immediate Cause (Final 4theosclerotic Onset and Death Physician/ andiovasulu disease or condition resulting in death) 427 Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: . If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Mulnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ျာ 1 Tes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Aursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 🗌 Yes 2 🗌 No ☐ Accident Investigation within 24 hours after deat To the Funeral Director: Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 814 person who completed cause of death (Item 23a) (Type, Print) egistrar's Signatur

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35371 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 1830 Thelma Lora Timmons tobe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Rehabilitation a Nursing Ctr ber 6. Sex 7. Age (In yrs. last dirthday) omico If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕱 F Months Days Hours Min (Month, Day, Maryland Yrs. Director 218-01-1176 90 Jan. Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f Parsonsburg MD Wicomico 1 Yes 2 No ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 7962 Esham Road 21849 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ò ģ 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural", Completed 3 ₩ Widowed 4 Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) seamstress garment company permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event; i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Corbett Lewis Ada Tyre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary L. Timmons 34698 (Son) 2920 Alt. 19 N Dunedin, FL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2011 Pittsville, Maryland Pittsville Cemetery Oct. 17, 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Short Funeral 13 East Grove Home Street Rusa Delmar, DE 23a. Part 1. Ent a the isease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or him failure. List only the industrial caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or him failure. List only the industrial caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or him failure. List only the industrial caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or him failure. List only the industrial caused the death. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eviliary cul Muroselentre Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner? Hospital: 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 W Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29c. License number 28769 29b. Signatu Name and address of person who completed cause of death (Item 23a) (Type, Print)

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DHMH 17 Rev 7/2009

Registrar

Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Norman Orville White October 40 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lorien Mays Chapel Timonium Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 **X** M 2 □ F 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) March 28,1924 Days Hours Min Director 87 219-14-7275 Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 No Maryland Washington Williamsport 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 10613 Harry Heth Road 21795 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Midowed 4 ☐ Divorced Completed Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Supervisor Power Plant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Norman Wesley White Almeda Pearl Hartell traumatic permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other <u>Donna Hallengren (Daughter</u> <u>26 Gorsoch Road Timonium, Maryland 21093</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State injury or 4 Donation 5 Other (Specify) Hagerstown Crematory Oct. 25,2011 Hagerstown, Maryland Signatur 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 211 0 disease or condition Cord Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year signed by the a g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> Completed 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed death? 24 hours after death. e Funeral Director: After this certificate holeted filled in by the funeral director, pag 2 🗌 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 10 2 200 Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending work? 2 Accident
3 Suicide Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🛄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 only one Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu and title of certifie 29c. License number RO79544 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUE B. ANTHONY

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Hopth 2011 Medical Facility Name (if not institution, give street and number) Examiner 4c. County of Death utimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Director** 525-80-3000 1 □ M 2 💢 F 72 07/19/1939 Kansas 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tyes 2 X No Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1720 Temi Drive 20601 USA 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. Completed by 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 Yes Specify: White 1 ☐ Yes 2X No Specify. If Yes, Give 3 🕅 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Henry Myers Nellie E. Gibson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alisa M. Jacobs/Daughter <u>30520 Serenity Lane, Charlotte Hall, MD 20622</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-EcholsCrem. 10/20/2011|Charlotte Hall, MD 21. Signature of Funeral Service Licer 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physici_n disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events Due to lor as a consequent Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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Registrar DHMH 17 Rev 06-2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 200 AM WOOD BURN Year ZOII TAMES HENRY 24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death ST. MMY'S HOSPITAL MARY LEONARDTOUN 5. Social Security Number 6. Sex Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 ☐ F Hours (Month, Day, Year) 09/25/1926 Director 213-22-0783 85 Maryland Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2X No Maryland St.Mary's Bushwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20618 USA 23028 Maddox Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 🔲 Yes 1 Yes 2 No Specify: If Yes, Give Specify: White 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Henry Tester Woodburn Mary Grace Heard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsye Mae Woodburn/Wife 23028 Maddox Road, Bushwood, MD 20618 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart 10/29/2011 Bushwood, MD Signature of Funeral Service Lines e 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, 1590 Fenwick Street, Leonardtown, P.A. MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) RESPERATORY INSUFFICIENC Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury MULMONARY that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician d be detached for use as the burial Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Yes 1 | Yes 2 | 9 | Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? FIRRILLATZON 24a. Was an After this certificate has I funeral director, page 2 s autopsy performed? Yes 2 N Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2.No ည 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nursus Fractioner: To the coal of my incompact of the time, date and place, and due to the cause(s) and manner stated. (Check id at the time, date and place, and due to the 29d. Date signed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	20a. Method of Disp 1 XBurial 2	osition	Removal from State	20b. I	Place of Dispo cemetery, crer	esition (Name of matory or other plating in the church in	@em	Date Date	20c. L	ocation - City	
	21. Signature of Fur	neral Service Lice			B E	Name and Addr ennie S uneral	ess of Facility Comith	917 W.	Isab	ella S	St.
	shock, or hear Immediate Cause (disease or conditio	t failure. List only Final	np cations that cause one cause on each line	d the deat e.							Approximate Interval Between Onset and Death
	resulting in death)	(Due to (or as			Gammo	201 4014				
Examiner	if any, leading to immediate Due to (or as a consequence of):							-			
ह्य	Cause (Disease or that initiated events resulting in death) L	3 1	c. Due to (or as	a conseq		FETVIL	r Q 1				
Medic	IF FEMALE:					, - ,					
Completed by Physician/Medic	23b. Was decedent in the past 12 r 1 Yes 2 1 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a	2 Feta	aldeath 3 L	Ectopic pregnar Other (specify)	ncy		_	23d, Date of o	delivery Day Year
ted by Pl	Part II. Other signif	icant conditions	contributing to death b	out not res	sulting in the u	nderlying cause g	iven in Part I.				to the cause of death? Probably 4 Unknown
									Was an autopsy performed? Yes 2	prior to death	autopsy findings available o completion of cause of ? /es 2 4 No
To Be	25. Was case referre examiner? 1 Yes 2		Hospital:	ent 2 🗆	ER/Outpatier	Ot	Place of Death (Cher:	g Home 5	Residence I	6 ☐ Other (Sp	ecify)
Certificate: 7	27. Manner of Death 1 M Natural 2 Accident	5 Pending Investigation	28a. Date of inju (Month, Da	iry y, Year)	28b. Time of injury	28c. Inju wol M 1	ry at		ibe how inju		
al Cert	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory building, etc. (Specify)					t, factory, office 28f. Location (Street and City or Town, State) cured at the time, date and place, and due to the cause(s) and		e)			
Medical	(Check 2	Medical Exan	vsician: To the best of niner: On the basis of e rse Practioner: To the	xaminatio	n and/or invest	tigation, in my opir	ion, death occurr	ed at the time, c	late and place	e, and due to the	e cause(s) and manner stated
	29b. Signature and t	itle of certifier	aure			29c. Licens	se number 2014 5 Salis		29d. Da	ate signed (Mor	nth, Day, Year)
					23a) (Type, F						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

rerry vvilley	State of Maryland / Department of Health and Mental F 1-For State Registrar Certificate of Death	łygiene	9.5.0.	011 25
Physician	Decedent's Name (First, Middle,Last)	2. Date of D	Reg. No.	3. Time of Death
Medical Examine	Telly Lee Willey	Month October		1151 hrs
	4a. Facility Name (if not institution, give street and number) 1510 South Salisbury Blvd. 4b. City, Town, or Location of Death Salisbury	h	4c. County o	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr.	s. 8. Date of	Wicomic	Birthplace (State or
Director	213-78-7653 1X M 2 F 49 Yrs. Months Days Hours Mir	1.	1962	Foreign
any	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	100 20	711502	Country Marylan
E	h			10d. Inside City Limi
the Marylan a or 28a-f st	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	
ith the 1 23a or notifie	21826		USA	, .
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 33s or 28s-f sho cut, the Medical Examiner must be notified at once. Be Completed by Funeral Director	1 Never Married 2 Married Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin? (Sp. 15. Was Decedent of Hispanic Origin?)	pecify Yes or N Rican, etc.)		American Indian, Black,
s after or niner or by Fe	3 Widowed 4 X Divorced of Yes, Give Year Armyz 1 Yes 2 X No specify:	,		
136 thin 72 hours after the "astural", edical Examiner	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	vork done	Specify: 16b. Kind of Busi	White ness/Industry
5-0036 led within 72 hour tygiene. other than "natte Medical Exar	α Ι	red)		
15-00 lled wit Hygien 1 other the Ma	17 Fethods Name (First Mark) Custom Painter	(First, Middle.	Temple F Maiden Surname)	Hill Motel
21215-0036 ould be filed within 7 d Mental Hygiene. s marked other than ite event, the Medical TO Be Comple	Gene Tunney Willey Sr.	Paul or		
U # 5 5 5 1 1	19b. Mailing Address (Street and Number or R	tural Route Nu		
ore, MI ses 1 and 2 s of Health a If item 27	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery	Dury, M	aryland 2	1804 ity or Town, State
Baltimore, permit. Pages I a Department of He Important: If ite	4 Donation 5 Other Specify: Salisbury Crematory 10/6	5/2011		
Baltimo permit. Page Department of Important: injury or oth	21 Signature of Funeral Service Licensee 22 Name and Address of Facility 7	- D 3		ry,Maryland
Physician	23a. Part I. Enter the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.	Salisbu	ry, Maryl	and 21804
/Medical Examiner	Immediate Cause (Final disease a Atherosclerotic Cardiovascular Disease	respiratory an	est, shock, or heart	Between Onset and
	or condition resulting in death) Due to (or as a consequence of):			Death
Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
1 5	Course. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):			
ecuted and transit	d			
68760, certificate be executed nding physician and se as the burial - transit	☐ AMENDED 23a,27,per me,g921 11-8-11 sm			
Box 6876 the death certificate the attending phy hed for use as the 1 hysiclan/M	F FEMALE: 2.3b. Was decedent pregnant in the past 12 months? 1 Live birth		23d. Date of del	ivery
	1 Yes 2 No 9 University 4 Pregnant at time of death 5 Other (Specify)	су	Month	Day Year
Division of Vital Records, P.O. Box the Hospital or Attending Physician: The law requires that the death thin 24 hours after death. The Funeral Director: After this certificate has been signed by the attentible of the funeral director, page 2 should be detached for using a feet of the file of the funeral director, page 2 should be detached for using a feet of the file of the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach stiffication: To Be Completed by P.				e to the cause of death? Probably 4 Unknown
Records, The law require ficate has been si , page 2 should bb Completed		24a. Was a		autopsy findings available
Reco		autops	prior ned? deat	to completion of cause of n?
ital Rec	5. Was case referred to medical examiner? 26. Place of Death (Check online)	1 Yes 2 ly one)	No 1	Yes 2 No
n of Viding Physia. After this funeral discon: To		Home 5 F	Residence 6 🗸 O	ther: Scene
Division of spital or Attending hours after death. neral Director: Aft filled in by the func Certification:	1 X Natural 5 Pending (Month, Day, Year) 226. Infine of Injury at Work? 28. Injury at Work?	3d. Describe h	ow injury occurred	
Division Oppital or Attent hours after death meral Director: y filled in by the Certificatio	Accident investigation	8f. Location (St	reet and Number or	Rural Route Number, City
Divi Dapital or hours after hours after meral Dir y filled in I	4 Homicide determined (Specify)	or Iown, Sta	ate)	
To the Howithin 24 h. To the Function 24 h. Completely completely Medical (The chart of the course of the	e to the cause	(s) and manner as s	tated.
Ned Spirit	29c. License number			
	labrelied O.C.M.E.		29d. Date signed (A October 5, 201	
33	7. Name and address of person who completed cause of death (Item 23a)			
State 31	Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD. Date filed (Month, Day, Year) Registrar's Signature	21223		
Registrar	Date filed (Month, Day, Year) O 1 1 2011 Registrar's Signature			
DHMH 17 Rev 1/2001 OCME 2006	OCALE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER JAMES L. WYATT 4:30 P M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCE GEORGE'S HOSPITAL PRINCE GEORGE'S CHEVERLY If Under 1 Year | If Under 24 Hrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 7. Age (In yrs. last birthday) MAY 5 Hours 1 ★ M 2 □ F 579-70-1463 57 1954 WASHINGTON, DC Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 X Yes 2 No MD PRINCE GEORGE'S UPPER MARLBORO 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 14504 TURNER WOOTTEN PKWY 20774 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ö 1 Never Married 2 Married þ Yes 25 No Yes, Give Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: AFRICAN AMERICAN "natural", 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 4 MARTIAI other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ should be ROBERT WYATT UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau KAREN LAWRENCE/PERSONAL REP. 6309 JUANITA COURT SUITLAND, MARYLAND 20746 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BRENTWOOD, MARYLAND LINCOLN CEMETERY 10-21-2011 4 Donation 5 Other (Specify) FT. 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease or complications that caused the death. shock, or heart failure. List only one cause on each line. de of dying, such as cardiac or respiratory Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease of impury Examine Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last ng physician a Physician/Medical Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? ξ Other (specify) Pregnant at time of death J Yes 2 □ No been signed by the should be detached 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 4 Unknown 1 Yes No Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital director, Be 26. Place of Death (Check only one) Hospital: မှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of De th Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1
Yes Certificate: 28d. Describe how injury occurred After Natural 5 Pending iniury 2 🗌 No nours after death, neral Director: A I filled in by the fu Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. eted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I comple only one) 29d. Date signed (Month, 29b. Signature and title 29c. License number State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35378 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month October 8:00 PM White 2011 annie 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Villa Rosa Nursing Home Mitchelleville (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (II 80 **Funeral** Days Hours 1X M 2□ F 3-1-1931 Elizabeth City, NC 243-42-0119 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at MD Seat Pleasant 1 X es 2 No Prince George's Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20743 416 71st Ave. United States Funeral 14 Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) ene. Elementary/Secondary (0-12) College (1-4or 5+) 5th Iron Worker Private permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygis Important: If Item 27 Is marked other i any Injury or other traumatic event, <u>tr</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie White Lucinda Shannan ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 71st Ave. Seat Pleasant, MD 20743 Vernette R. White (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 NBurial 2 Cremation 3 Removal from State Fort Linoln Cemetery 10/19/2011 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Spice Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, MD 20722 Thon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Stage **Physician** nd /Medical Due to (or as a consequence f) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner sician and burial-transit certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician s the burial Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy signed by the atte Day 4 □ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' 1 Yes 2 Ho Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending (Month, Day Year) 1 Matural 5 Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director. A 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. title of oertifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and

CR 3

State Registr<u>a</u>r 31. Date filed (Month, Day, Year)
OCT 2 9 2011

Seay

2835 Smith Avenue Ste 203

30. Name and address of per who completed cause of death (Item 23a) (Type, Print)

00053337

10/17/2011

Buttowne, Milzizos

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#5perFH, G921, 11/7/2011 WS State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 18, 201 far 0639 John Andre' Winchester Sr. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's County Callaway Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** Sex 1 M 2 □ F Country) DC <u> 5777-68-8962</u> Months Hours Min. May 30, Yar 952 Director 59 Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 X Yes 2 No Chaptico St. Mary's Maryland | 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral United States 20621 36036 Bay Drive be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. African þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 A No Specify: Yes Give 3 Widowed 4 Divorced Completed Year or Dates Ämerican 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Heavy Duty al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Private Equipment Operator event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental H ည Annie Vernell Johnson permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic or Johnny Winchester other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 6806 Walker Mill Road Apt. 301 Capitol Heights, Md. Deborah R. Winchester - Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Dotober 25. 1 A Burial 2 Cremation 3 Removal from State Laurel, Maryland Maryland National 2011 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, Inc. True 4001 Benning Road NE 20019 round Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the de of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to for as a consequence of cause. Enter Underlying sician and burial-trans Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death detached the Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? **^**q 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? nin 24 hours after death.

the Funeral Director: After this certificate hapleted filled in by the funeral director, page Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 **X** No Other: မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) the Hospital Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1005575 10/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leonardtown, Md. 20650 Schmidt, MD 40900 Merchants Lane Suite 205, Jennifer State 2 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 7:30 A.M Donald Rex Arnold Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Genesis Eldercare - Corsica Hill Queen Annes Centreville 9. Birthplace (State or Foreign Country) Tennessee 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🕱 M 2 🗆 F Months 05705/1922 408 38 0988 89 Director Usual Residence of Decedent show 10d. Inside City Limits f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director Queen Annes Stevensville 1 Yes 2 X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S. 21666 313 Virginia Road Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes. Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Rigger / MD Dry Dock Ship Building 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Josie Thacher Edd Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Arnold / Son Stevensville, Maryland 21666 313 Virginia Road 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 11/02/2011 Baltimore, Maryland Loudon Park Cemetery! 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each line the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betw Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner 10ars Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last lears Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Natural 5 \square Pending 1 Yes 2 No Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of terson who compl

limans Lane,

cause of death (Kem 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

32. Reoftrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35382 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Wember 2 2:31 PM Physician/ Medical own, or Location of Death Facility Name (if not institution. County of Deatl **Examiner** tune Medica en If Under 1 Year 9. Birthplace (State or Foreign Country) MD If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1**X** M 2 □ F Min 1/2017/3 PEY/Y9957 MD Director 53 217-66-3424 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Anne Arundel MD Severn 1 🗌 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21144 Funeral USA 1550 Monard Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. White Armed Forces þ 1 Never Married 2X Married 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tow Truck Driver Auto 8yrs Be Father's Name (First, Middle, Last)
William Auburger Sr. 18. Mother's Name (First, Middle, Maiden Surname)
Lillian Roloson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1550 Monard Ave Severn MD 21144 Wife Kimberly Auburger 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory or other place Glen Burnie MD 11/04/11 Sign start, of Jun ral Service Licenses 22. Name and Address of FacilitySimplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 065 years disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law Incursal Brector: After this certificate has been signed by the attending physician and eted filled in by the furnerial director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No မှ 1 Tes Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work?
1 \(\sum \) Yes 2 \(\sum \) No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) To the Hospital of within 24 hours as To the Funeral D. Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35383 1 - State Registral Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November Day Year 3-05PM BROWN Physician/ 20il FRANCES Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner CARROLI ATRY MOUNT NURGING HOME PLEASANT VIEW 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Feb 2 If Under 24 Hrs If Under 1 Year . Age (In yrs. last birthday) Social Security Number Country) Days Hours Min. **Funeral** 1979 1 M 2 XF 82 213-26-4850 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10b. County 10a. State notified at Director 1 Yes 2 No Mt. Airy MD Carrol1 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number er than "natural", or items 23a on the Medical Examiner must be USA Funeral 21771 4101 Old National Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married è Specify: white 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 3 X Widowed 4 Divorced Completed Year or Dates. 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) health care al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) dietary aide 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) should be file and Mental H is marked of Nellie Viola Foster ည William Earl Whitlock permit. Page 1 and 2 should be Department of Health and Merr Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship **(Mare)** Mr. Stephen E. Ridle/ 7310 Gaither Rd., Sykesville, MD 21784 son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Toremation 3 Removal from State Sykesville, MD County Cremation 11-8-11 A11 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Parge Harghi Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final VENTRICULAR FAILURE EFT Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CORONARY ARTERY DISEASE Sequentially list conditions, Due to (or as a consequence of, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury H PERTENSION attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Year Month Day in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the at d be detached for 1 ☐ Yes 2 ₹ g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 2 HEMI PLESIA LEFT STROKE Completed 24b. Were autopsy findings available prior to completion of cause of death? peen : 24a. Was an DEMENTIA autopsy has performed Y 2 M No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be Other: 4 ✓ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျှ 28d. Describe how injury occurred After this 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death Certificate: injury work 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after death completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide
4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check within 2 only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier November 51x. 2011 D. 30469 6 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.B. VELLANKIMD, 8850, COLUMBIA 100 PARKWAY \$308, COLUMBIA; MD. 21045. 32. Registrar's Signature State arka Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 35384 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1:15 PM Sarah Medical Burns 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. Country Director 259-32-6357 1 M 2 XF 86 01-01-25 GA Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shorexaminer must be notified at Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2700 Charles Street 21218 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African þ 1 Never Married 2 Married 1 Yes If Yes, Giv 2X No Baltimore, Maryland 21215-0036 han "natural", c 1 Yes 2 No Specify. Specify: American 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the other homes 5th Grade NA Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk. should be file and Mental F is marked or ဂ္ E11a Sullivan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health Ella Pitt-Niece 1202 Windemere Avenue Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 XBurial 2 Cremation 3 Removal from State Woodlawn Cem. 11-11-11 Woodlawn, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. Street Baltimore, MD 21217 638 N. Gilmor 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician)rosepsi4 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as onsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown P.0. signed by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performed 2 X No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 1 Inpatient 2 욘 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 2 Accident 5 Pendina 1 Yes 2 No Investigation filled in by the after death 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled Medical certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar

State

Marta Mike

2011

31. Date filed (Month, Day,

NOV 07

Ave

t University

32. Registrar's Signature

BALTMORE

MD 21218

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 9:52 P. M Margaret May Bents October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 341 Green Aspen Court Millersville Anne Arundel Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth **Funeral** Days (Month, Day, Year) Months Hours 212 22 6717 **Director** 1 🗆 M 2 🔀 F 85 05/19/1926 Maryland Usual Residence of Decedent 28a-f show 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 Y No Maryland Anne Arundel Millersville 10e. Street and Number 10g. Citizen of What Country? 341 Green Aspen Court 21108 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. þ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: er than "natural", the Medical Exal Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Computer Programmer U.S. Navv Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental | is marked c ပ Stanley Degges Martha Tipton traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ye 1 and 2 s it of Health a If item 27 i 1252 Rock Hill Road Stephen Bents / Son Pasadena, Maryland 21122 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State injury or Department of Important: If any injury or Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, 4001 Ritchie Highway Baltimore, Maryland 21225 namerous 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final FRILURE TO THRIVE Ph si i n disease or condition resulting in death) Medical Due to (or as a consequence of) OBSTructive Polymonery Diserse Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last buriatphysician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No signed by the a 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy performed death? certificate | 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 11 10 Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No neral Director: A filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital 24 hours a Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my oninion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2

To the F 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12011 131 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVERINA PACK IMD Robinson ROND KATZ, mo 31 Steriten

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

NOV 0

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35386 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ DUEMBER ewel Edna Medical 4a. Facility Name (if not institution, give street and number) **Examiner** County of Death tonsvill more 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min Director 1 🗆 M 2 🗹 F 86 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No mn imorc 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 12. Was Decedent Ever in J.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Newer Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 3 ■ Widowed 4 □ Divorced "natural" er than "natur , the Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life_DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Service 7 is marked other the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Department of Health ar Important: If item 27 is any injury or other trauonce. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee meene Kanda Ilstown 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): [']Examiner Sequentially list could s, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): the burial-transi To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death been signed by the a should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Medical Certificate: To Be Completed by DEMENTIA 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s after death.

Director: After this certificate has page 2 s autopsy performe death? 2 No 1 Yes 2 No 1 Yes filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending injury work? 2 🗆 No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of D0061765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
33. Name and address of person who completed cause of death (Item 23a) (Type, Print)
36. Name and address of person who completed cause of death (Item 23a) (Type, Print)
37. Name and address of person who completed cause of death (Item 23a) (Type, Print)
38. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Sta	of Marylar	nd / Depa 11/28/	artment of 2011dhb.	Health a	and Mental	Hygiene Reg. No	2011	35387
			Decedent's Name (First, Middle, Last)			imouto or	Dodin			/25/201	1 3. Time of Death
	Physicia Medic		Louise Cecelia Bay	lor				OCT (Year Year	- S:00 PM
1	wedic Examin		4a. Facility Name (if not institution, give street and nur			4b. City, Town,	or Location o			c. County of Dea	ath ,
-	~		Civista Medical Cent	er		L	a Pla	rta		Cha	rles
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days			of Birth 7, 64/ 199	9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent	6	2 Yrs.			12/	16719	40 Ma	Tyland
	and show at	ъ	10a. State 10b. County	10c. Cit	ty, Town or Loc	ation					10d. Inside City Limits
	/laryla 8a-f tified	Director	MD N/A			Balti	imore				1 ⊑xYes 2 ☐ No
\cap	the h	٥	10e. Street and Number	L		10f. Zip Code			10g. Ci	itizen of What C	ountry?
2	n with	Funeral	210 N. Glover St.			2	21224		1	U.S.A.	
7	death ritem nern	[₽	Armed Fo			Vas Decedent of Yes, specify Cub	Hispanic Orig ban, Mexican	gin? (Specify Yes or , Puerto Rican, etc	No-	14. Race - Ame Black, Whit	
298	after al", or xami	d by	If Yes, Gi	2 □½ No ⁄e	1	☐ Yes 2 🛣N	lo Specify:			Specify: Bl	
7 8	nours natura ical E	ete	15. Decedent's Education		16a. Deced	ent's Usual Occu	upation		16b k		
21215-0036	n 72 ł e. an "r Med	Completed	(Specify only highest grade completed Elementary/Seconday (0-12) College (1		(Give k	ind of work done NOT use retired	e during most d)	of working		Kind of Business rcuit	
	withi		11th Grade		Cour	troom (Clerk		Ba	ltimor	e City
Z G	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 'is marked other than "natural", or items 25a or 28a-f sho 'is martic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					er's Name (First, Mi			
	uld be d Men narke natic	-	Lewis Roechester Dys	on	1			nice Fe			21220
Maryland	2 sho th and ?7 is r traur		19a. Informant's Name/Relationship (Type, Print) Tonia Dyson(daughter	`	19b. Mailin	g Address (Stree	t and Numbe	r or Rural Route Nu	ımber, City oı ↑† H	r Town, State, Zi	more, MD
	and Healt tem 2		20a. Method of Disposition			sition (Name of	1	Date		ocation - City o	
√ <u>o</u> r	age 1 ent of nt: If i		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	State	cemetery, crem	natory or other plansk Ce		11/05/1		ltimor	·
//O(/ L/ Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	3	21. Signature of Funeral Service Licensee	110				own Jr.	_		
_ m	permit Depar Impor any in		Dietich N. ll	Mella	n 2	140 N.	Fult	on Ave.	, Bal	timore	, MD 21217
\sim			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on earths.	caused the deat	h. Do not ente	4	_	5 ()			Approximate Interval Between
-	Physician/		Immediate Cause (Final disease or condition	110+1.	into	m O	rea	n Farl	ue	,	Mille
-	Medical Examiner		regulting in death)	or as a consequ	ue ice of);	D. A	000	n Farl			
		-E	Sequentially list conditions, b.	Sunt	m	Kech	y C	wneer			gravo
۸.	ed sit	Examiner	if any, leading to immediate Due to cause. Enter Underlying Cause (Disease or iinjury	(or as a consequ	uence of):						
£14	be executed sician and burial-transi	Еха	that initiated events c	or as a consequ	uence of):						
909	ite be executed hysician and he burial-transit	dical	d								
6876		Med	IF FEMALE:								
% %	eath certifical attending ph I for use as th	an/I	23b. Was decedent pregnant 23c. If yes, ou	come of pregna	ancy al death 3 🗆	Ectopic pregnar	ncv			23d. Date of de	,
Box	e death the att hed for	Physician/Me		nant at time of		Other (specify)			-	Month	Day Year
P.O.	hat the ed by t detach		Part II. Other significant conditions contributing to c	eath but not res	sulting in the ur	nderlying cause o	given in Part I	230	Did tobacco	use contribute t	o the cause of death?
	requires that the de been signed by the should be detached	Completed by				rading radio s	9.7011.111			A:	Probably 4 Unknown
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ecc	The law cate has page 2 t	mp							autopsy performed?	death?	utopsy findings available completion of cause of
<u>=</u>	iician: The law certificate has rector, page 2		25. Was case referred to medical			26.1	Place of Deat	h (Check only one)	Yes 2 N	io 1 ∐ Ye	es 2 No
Vita	ysicia s cert direct	To Be	examiner? 1 Yes 2 No Hospital:	Inpatient 2 🗆	EB/Outpatien		her	rsing Home 5	Besidence f	6 Other (Spe	cify)
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on	eath. or: Af the fur	fica	1 Natural 5 Pending (World 2 Accident Investigation 3 Suicide 6 Could not be	,,,,	,,		Yes 2	No			
Division of Vital Records,	I or Attendi after death. Director: A I in by the fu	Certificate:	28e. Place	of Injury - At hong, etc. (Specify	ome, farm, stre	et, factory, office			ion (Street an r Town, State		ural Route Number,
Ö	pital		29a. Certifier 1 Certifing Physician: To the b	oot of my know	ladge death o	soured at the tim	- data and r	alone and due to the	20.00(0) 00	nd mannor on o	totod
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to	Medical	29a. Certiffer (Check only one) 3 Certifying Physician: To the b	is of examination	n and/or investi v knowledge d	gation, in my opir	nion, death oc	curred at the time, of	date and place	e, and due to the	cause(s) and manner stated.
	To the comp	2	29b. Signature and title of certifier	11/1/2		29c. Licen		and protos; and date		ate signed (Mon	7
				1000	0	0-	466	119	1	0/24	0/201
	10		30. Name and address of poson who completed caus	se of death (Item	23a) (Type, P	rint) / 1	. 4	101	1 4	10	
	1		Charlene Letchtord	MU, S	Gan	rett A	Ve l	a Plan	a, 11	10 200	046
	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 7 2011	egistrar's Signat	ture 1. Span	Kal					

State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 12:388 M Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death 9. Birthplace (State or Foreign If Under 24 Hrs. 8 Date of Birth **Funeral** 1 🗆 M 2 🗗 Director 28a-f shov 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral . Was Decedent Ever in US Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ō 1 Never Married 2 Married Completed by Yes Yes, Give Saltimore, Maryland 21215-0036 1 Yes 2 No "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) LERA Be 17. Father's Name (First, Middle, Last) 18, Mother's, Name (First, Middle, Maiden Surname) RICHARD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Pineral Service Lic 22. Name and Address of Facility Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 23a. Part L. Ent Approximate Interval Between nset and Death Immediate Cause (Final Physician/ pronous disease or condition resulting in death) Medical Due to (or as a consequent of) Examiner Mabetur Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician a for use as the burial-Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown Unknown signed by t t be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has all director, page 2: 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Other: 1 🗌 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work? 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: / 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🔭 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 57088 NOV 2, 2011 Thow POON, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST 301 30 timer 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day September Year 201 Physician/ 28, 5:20 PMM Lee Burgess Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Blue Point Nursing Home Baltimore 8. Date of Birth (Month, Day, Year) Jan 4, 1933 Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Min. South Carolina 1 🔀 M 2 🗆 F Hours Director 78 248-50-9562 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location Director 1 √2 Yes 2 □ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2200 Homewood Avenue 21218 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: black 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) construction laborer unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Laura Burgess Franklin Singletary 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1543 Alconbury Road Baltimore, MD 21221 19a. Informant's Name/Relationship (Type, Print) 1543 Alconbury Road Baltimore, MD Creola Hall/cousin 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite cemetery, crematory or other place) injury or 1 Durial 2 Cremation 3 Removal from State 4 Donation 5 N Other (Specify) in state Sig ature of Constal Service Lice any inj once. State Anatomy Board 655 W. Baltimore Street 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a, Par shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician 20 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Samo Sequentially liet conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of WPG 10 Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: fyes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ within 24 hours after death.

To the Funeral Director After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Month Day Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 × No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 🛮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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EUT AW ST

Bal house

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

NOV 0 7 2011

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32. Registrar's Signature

11-07686 В

elinda Brown		State of Maryland / Department of He				25200
silida Diomi.		1- For State Certificate of Dea			2011	35390
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,Last)		Reg 2. Date of Death	. No.	3. Time of Death
ledical Exami		Belinda Brown		Month October 13	Day Year , 2011	2300 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City	y, Town, or Location of Deatl		4c. County of Death	
		Bon Secour Hospital Bal	timore			
Funeral		· GIII	nder 1 Year If Under 24Hrs		(MM/DD/YYYY) 9. Birt Foreig	
Director		1 M 2 F 49 Yrs. MO	nths Days Hours Mir	Aug 8,		untry)
,		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
эм ану						1 Yes 2 No
Aaryland 28a-f show 1 at once.	tor	MD Baltimor	Zip Code	1100	j. Citizen of What Cour	Λ
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Fleaduand and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	2023 Wilhelm Street	21223	100	USA	iu y r
ith th			edent of Hispanic Origin? (S	necify Ves or No.	14. Race - Americ	can Indian Black
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fter d		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes	2 X No specify:		Specify: b1	ack
ours a	d by		al Occupation (Give kind of		16b. Kind of Business/I	ndustry unk
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Shoul shoul and h	은		Baltimore St			21223
and 2 sealth tem 2 traum		20a. Method of Disposition 20b. Place of Disposition (N			20c. Location - City or	
ges l t of H		1 Burial 2 Cremation 3 Removal from State crematory or other plan	ce)			
fim. Partmen		4 Donation 5 X Other Specify: in state	and Address of Eacility			
Ba Deerm Depa Impo			ndAddesoffgeilBoar		Baltimore	Street
Physician		23a. Firt I. Enter the discusse, or complications that caused the death. Do not enter the mod failure. List only one cause on each line Pulmonary Thromboembo	nore, MD 212 le of dying, such as cardiac c	OT or_respiratory_arres	t, shock, or heart	Approximate Interval
/Medical				deep ven	ous	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Thrombosis of right lower condition resulting in death)	er extremity			
	.	Sequentially list conditions, b				
	ine	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
_	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
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Box 68760, death certificate be the attending physici death ous as the burn	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
ox 687 eath certific attending p	ian	past 12 months?		ancy	Month D	ay Year
Box e death the atte	ysic	1 Yes 2 No 9 ✓ Unknown 9 Unknown	oecity)			
		Part II. Other significant conditions contributing to death but not resulting in the underlying	ng cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
res this signed be de	d b	Asthma; Morbid Obesity		1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
rds requi	Completed			24a. Was an autopsy		opsy findings available ompletion of cause of
e law te has	Ĕ			perform	ed? death?	
n: Th		25. Was case referred to medical	26.Place of Death (Check		NO 1 V	2 110
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	B B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3	DOA Other Nursin	ng Home 5 Re	esidence 6 Other	
ling Ph	12	27. Manner of Death 28a. Date of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how	w injury occurred	
		Natural 5 Pending	1 Yes 2 No			
Division tall or Attendin rs after death.	<u></u>	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factor		eet and Number or Run	al Route Number, City	
Division or At ours after defined in by	Certification:	4 Homicide determined (Specify)	10	or Town, Stat		
E Hos 24 hc e Fun etely		29a. Certifier (Check only) Certifying Physician: To the best of my knowledge, death occurred at the control of the control o				
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in and manner stated.				
	Σ	29b Signature and title of certifier	29c. License number		29d. Date signed (Mon	
		mesc	O.C.M.E.		October 14, 2011	
		30 Name and address of person who completed cause of death (Item 23a) And Rubin MD Assistant Modical Examiner 200 W Retimors	Stroot Politica AAT	7 21222		
		Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore	otreet, baltimore, Mi	J 21223		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

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State of Maryland	Department of He	ealth and Mer	ntal Hygiene

3539 Wilmer Franklin Beard 1- For State Certificate of Death Registrar Reg. No Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month Day October 29, 2011 Medical Examiner 1209 hrs Franklin Reard Wilmer 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 14 E. Frederick Street Walkersville **Frederick** 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) **Funeral** Foreign Country) MD Months Days Hours Min Director 1 X M 218-24-9293 2 F Dec. 17, 1928 82 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Frederick Walkersville Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14 E. Frederick St. U.S.A. 21793 Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 X Never Married 2 1 X Yes 2 1 Yes 2 X No specify: 3 Widowed 4 Divorced If Yes, Give Year 1948-53 Specify: White 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) d other than " Baltimore, MD 21215-0036 11 Tile setter Flooring 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Wilmer L. Beard Mary Catherine Keeney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tment of Health and Mortant: If item 27 is may go or other traumatic e Frederick, MD 21701 9220 Oak Tree Circle Ronald Wesley Brown/cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Rocky Hill Cemetery 11/3/2011 | Woodsboro, MD Donation 5 Other Specify. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hartzler Funeral Home Jana 404 S. Main St., Woodsboro, MD 21798 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last death certificate be executed pur cal UNPENDED AMENDED signed by the attending physician be detached for use as the burial -Physician/Medi Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day Fetal death Month Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive Atherosclerotic Cardiovascular Disease; Diabetes Completed has been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) æ examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene this 6 1 🗸 Yes 2 No 28a. Date of Injury FOUND: After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification Subject fell 1 Natural FOUND: after death.

Director: A in by the fu 1 Yes 2 V No Pending Oct 29, 2011 1115 hrs 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 14 E. Frederick Street, Walkersville, MD 4 Homicide determined (Specify) Single Family Home 29a. Certifier 1 npletely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 Medical one) 2 Wedlcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. October 30, 2011 30. Name and address of person who completed cause of death (Item 23a) 10 V Deputy Chief Medical Examiner Jack Titus MD. 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day 32. egistrar's Signatu State

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A BEAUCH

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3, **Physician** 2011 November Besore' 5:20 p^M Η. Jessie /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Broadmead Cockeysville 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthdav) Funeral Months Days Hours Min. 1 □ M 2 □,F 94 Director 216-46-3195 July 4, 1917 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Eventing must be notified at 1 ☐ Yes 2 🙀 No Director MD Baltimore Cockeysville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 13801 York Road Room 268 21030 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify White <u>ک</u> 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other t any Injury or other traumatic event, In 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harrison Bull Simon Henry Helen ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Brandon Road, Baltimore, Anne B. Stephanus-daughter MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hilltop Serv Corp 11/5/11 Towson, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funneral director, page 2 should be detached for use as the burial-transit completely filled in by the funneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical 687 Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Day Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown icate has been signed by page 2 should be detact 23e. Did tobacco use contribute to re cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. Be Completed by 3 √ robably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed?/ 1 Yes 2 12 No Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 12 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Division of 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10/2 30. Name and address of person who cor 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

7 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** :30P M 10 5 2011 Eugene Norman Cherry Jr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital 5. Social Security Number | 6. Sex | 17 Kosedale Center Baltimore Birthplace (State or Foreign Country) 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral **1** M 2 □ F Months Days Hours Min. Director March 14,1981 Mary.land 213-08-8844 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits 10h County show 1 XYes 2 □ No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mary Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sh any injury or other traumatic event, Its Medical Examinat he rotifical any injury or other traumatic event, Its Medical Examinations. Director Baltimore Maryland N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3403 Mayfield Avenue 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Yoo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 □Yes 2 No Specify: Black Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Disabled N/A <u>12th grade</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene N. Cherry, Sr. Wanda D. Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda D. Harris/Mother 924 Chesaco Ave. Rosedale, MD 21237 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 11/04/2011 Daklawn Cemeterv Baltimore,MD 22. Name and Address of Facility Chatman—Harris Funeral Home 21. Signature of Funeral Service Licensee Harre 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Renal /Medical Due to (or as a consequence of): Examiner irrhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached fo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Hepatorenal Syndrome 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☒No 24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident 1 □Yes 2 □No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide

P.O. Box 68760, Records, Division of Vital

Cherry Eugener Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Medical State

29a, Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Us Haroti' 069198 OCTOBER, 25,2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NOV 0 7 2011

Dr. John Kottarthil , 9000 Franklin Square Drive, Baltimore MD, 21237 MD 31. Date filed (Month, Day, Year)

Medic	al E	nysici Exami neral ector	
	vith the Maryland	s 23a or 28a-f show any e notified at ouce.	al Director

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charlene Colber	t	State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar Certificate of Death Reg. No.	91
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Vegs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Union Memorial Hospital 4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Yrs. Months Days Hours Min. 8/2/1970 Country)	
у апу		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	
Maryland 28a-f show d at ouce.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	10
ith the M		50 4 E. 4340 Street 2122 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - American Indian, Black,	_
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once.	/ Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year 1 Yes, Specify: White, etc. 1 Yes 2 No specify: Specify	
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and 2 sho tealth and tem 27 is traumati		LUIA Belle Scott 1921 E. Belvedere Ave Bullo MD Z/Z 20a. Method of Disposition (Name of cernetery, Date 20c. Location - City or Town, State	17
Baltimore, MD 21215-00: permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other tinjury or other traumatic event, the Med		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: Arbustus Cenetern 11 9/2011 Pro 150 Mi)
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	aminer	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	
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3760, ficate be g physicia s the buria	ı/Medi	123d. Date of delivery 23b. Was decedent pregnant in the	\exists
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physicin phetely filled in by the funeral director, page 2 should be detached for use as the buil	Physician/M	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year	
res that the signed by the be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive Atherosclertoic Cardiovascular Disease 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown	n
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of Vital ing Physician: After this certi uneral director	: To Be	examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 0OA Other Nursing Home 5 Residence 6 Other: 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	
Division (tal or Attendin, rs after death.	Certification	1 X Natural 5 Pending (Month, Day,Year) 1 Yes 2 No large investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, Ci	itv
Division To the Hospital or Attenti within 24 hours after death. To the Funeral Director: ,	Certifi	Suicide 6 Could not be determined (Specify) Or Town, State)	
To the Howithin 24 h	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	Σ	29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) November 3, 2011	
Orkers		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
St Regist	ate	31. Date filed (Mooth Day Year) 32. Registrar's Signature	\dashv

For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Challa combe Month Patricia Jane 0118 AM Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard County General Hospita olumbia Howard 5. 2012 S43+2215 6. Se **Funeral** 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, unk. 65 **Director** NY 1 🗆 M 2 💢 F Feb 25, 1946 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 280. ***—any injury or other traumatic account. items 23a or 28a-f shoner ner must be notified at Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3378 B N. Chatham Rd. 21042 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) **Food Service Food Service** INKNOWN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Franklin Challacombe Jane Francis Comesky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owen Clement 14 Mallard Way Sudburry, Sufolk C010 OYG 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory, LLC Nov 16, 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral 9 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Ph sician/ Onset and Death Respiratory disease or condition resulting in death) Medical Examiner neumonia if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Phila over load Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ bowel obstruction. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown should Intra abdomina 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 24 hours after death.

Funeral Director; After this certificate performed' 2 🗌 No ☐ Yes 2 No 1 Yes the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the P within 2, To the P only one) 3 □ 29b. Signature and title of certifier 29c. License number 042892 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ledar lane Francis 5755 21044 Chuidian

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Claire L. Curry Nov 6, 2011 Year 8:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death **Ellicott City** Howard **Encore Lorien of Ellicott City** 5. Social Security Number Birthplace (State or Foreign Country) Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Feb 27, 1921 Months Days Hours 1 □ M 2 🔽 F 033-18-1259 90 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10d. Inside City Limits 10c. City, Town or Location Funeral Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11150 Resort Rd. Apt 216 21042 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 Yes : 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **School Teacher** Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ **Edward Joseph Kelley** Agnes J. O'Brien 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
 1225 Hayleys Ct. Mount Airy, MD 21771 Edward Curry Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) metery, crematory or other place)
Atlantic Crematory, LLC Nov 07, 2011 Glen Burnie, MD 22. Name and Address of Faculty Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Ser e Licensee UZCr 23a. Part 1. 5t. In the dise is a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death eriphural Vascular Immediate Cause (Final Physician/ disease or condition resulting in death) / Medical Due to (or as a consequence of) Examiner Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last iding physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 month Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗆 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Assita Liva Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Tes 2 No Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) sob who completed cause of death (Item 23a) (Type, Print) Crup 33 31. Date filed (Mont Registrar's Signa State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Wovember Physician/ Clingan 7:05 aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bayview Care Center Johns Hopkins Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1 M 2 🗷 F Min. Director 216403831 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hyglene. Fath the state of Teams 23a or 28a-f sho tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho up or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 1 2 Yes 2 No Westminste 10g. Citizen of What Country? 10e. Street and Numbe Funeral 2623 2115 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 🗆 Widowed 4 🗆 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Be 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Morris Holland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lepartment of Healt.
Important: If item 27
any injury or other tra Clingan 262 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Allentown, PA 21. Signature of Funeral Service Licensee 1232 Midulley Dr. Jessey, PA 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death archilha: a Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of):
netastable Ovarian cuncer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine oridate certibral aven CVA To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 17,7362 Tens10 5 1 Yes 2 No 3 Probably 4 Unknown Deep Venans 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 욘 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1. Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 204383 Navember 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 Hopkins Ray Vian Cincle W. J. Greenschik No Baltinove no Single 32. Registrar's Signature State

Registrar

arks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 3 201 Team 06:30A M COLNES MARTIN BYRON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY 14809 PENNFIELD CIRCLE, #216 SILVER SPRING 6. Sex If Under 1 Year | If Under 24 Hrs. Social Security Numbe 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Hours Min 194-22-2738 1 🕅 M 2 □ F **Director** 84 09/04/1927 PAwith the Maryland at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 ☐ Yes 2 🕅 No MD MONTGOMERY SILVER SPRING 10e. Street and Number ò 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be r Funeral 14809 PENNFIELD CIRCLE, #216 20906 USA ural", or items ? Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Famer if item 27 is marked other than "natural", or items unry or other traumatic event, the Medical Examiner m. unry or other traumatic event, the Medical Examiner m. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) REPRESENTATIVE MANUFACTURING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ROBERT COLNES MARIE LAWRENCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 14809 PENNFIELD CIR., #216, SILVER SPRING, MD 20906 TOBIA COLNES/WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🔀 Removal from State cemetery, crematory or other place) 11/03/2011 EWING, NJ 4 ☐ Donation 5 ☐ Other (Specify) EWING CEMETERY SOL LEVINSON & BROS., INC. 22. Name and Address of Facility ROAD, PIKESVILLE, MD 21208 8900 REISTERSTOWN Part 1. Enter the disease, or complic shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Immediate Cause (Final Onset and Death Progressive Ph sician/ maelopath disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (of as a consequence of, Examir use as the burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) for in the past 12 months? Month Day Year Pregnant at time of death Unknown signed by the at d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed neec 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perform death? 1 Yes Yes the Hospital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? <u>1</u>0 Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) hours after death. uneral Director, After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work 1 Tes 2 🗌 No filled in by the 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifie

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

IRVING

MD 19539

29d. Date signed (Month, Day, Year,

3

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:45 P.M Willard Detzel October 0 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 3283 Ryerson Circle Baltimore **Baltimore** Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** Days Months Hours 214 16 5487 Director 1 X M 2 🗆 F 88 11/23/1922 Maryland Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Director must be notified 28a-f 1 Yes 2 XNo Maryland Baltimore Baltimore 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3283 Ryerson Circle 21227 U.S. or items 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give WW TT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify. "natural" Year or Dates. WW II Specify. White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) r than " Elementary/Secondary (0-12) College (1-4 or 5+) Truck Driver 6th Trucking Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, <u>tt</u> once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Tobias Detzel Gladys Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladys Blake / Daughter Baltimore, Maryland 21227 3283 Ryerson Circle 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11/03/2011 Cedar Hill Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final UPOSEPSis Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Il or Attending Physician: The law requires that the death certificate be executed affer death.

Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transif that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ALD performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Μ 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completely filled in by determined within 24 hours a To the Funeral Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Dav. Year) 2011

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of person who co

31. Date filed (Month, Day, Year)

808 LAHOMARX DRIVE SHITE 128 CLEHSHRHIE MD 2061

eted cause of death (Item 23a) (Type, Print)

WD

32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Rov Roosevelt Davenport, Sr. 12:05 PM October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore Baltimore N/A Social Security Number **Funeral** 8. Date of Birth (Month, Day, Year) May 19,1932 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Hours 230-36-2063 **Director** 1 M 2 F 79 Virginia show Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f N/ABaltimore 1 X Yes 2 No Maryland ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21215 USA 2802 Virginia Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. o þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Maryland 21215-00³6 permit. Page 1 and 2 should be filled within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar any injury or other traumatic event, the Medical Exar 1 Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Known as 6th grade Self Employed Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy R Davenport Unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2802 Virginia Avenue Baltimore, MD 21215 Sharon J. Davenport/Wife 21215 Baltimore, CHIST 20a. Method of Disposition 20b. Place of Disposition (Name of 11/7/11 20c. Location - City or Town, State tx Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Owings Mills, Maryland Garrison Forest vet. Cem. 21. Signature of Euneral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Sepsis Onset and Death Ph sician/ disease or condition resulting in death) days Medical Due to (or s a consequence of): Examiner schemic Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or injury Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical P.O. Box 68760 use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ 23d. Date of delivery in the past 12 months?
1 Yes 2 No for Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signe I be d þ Discuse, Hypertonsian Division of Vital Records, Kidney Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Disease. eripheral 24a. Was an page 2 autopsy performed?

1 Yes 2 No Thramboenhalic 1 Yes 2 No filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: မှ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident within 24 hours after death To the Funeral Director: A Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License numbe 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Sinai Hospital of Baltimore

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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			1 - State Registrar	•		ficate of L		a Mentarriy	Reg. No. 2 N	1 25101		
Ī	Physicia		Decedent's Name (First, Middle, Last) Eliaou	2		DAHAN		2. Date of De Month Novemb	eath Day Ye	3. Time of Death 1 6.20 P M		
	Medic Examin		4a. Facility Name (if not institution, give street and number,)	4	lb. City, Town, or	Location of De		4c. County of [
-1			Shady Grove Adventist Ho	ospital Age (In yrs. last birth	h day)	Rockvi	le If Under 24 F	Hrs. 8. Date of Bi		Montgomery 9. Birthplace (State or Foreign		
	Funeral Director		216-80-7594 1X M 2 G F	70	ruuy/	Months Days		fin. (Month, Day Mar	ay, Year)	Country) Morocco		
	faryland 3a-f show tified at	ector	10a. State 10b. County Maryland Montgomery	10c. City, Town	or Locat					10d. Inside City Limits 1 ☐ Yes 2 🕅 No		
	with the N 23a or 2i 1st be not	Funeral Director	10e. Street and Number 11801 Rockville Pike, #1	.507		10f. Zip Code 2 (0852		10g. Citizen of Wha			
036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Deceden Armed Force 1 Yes 2 If Yes, Give	t Ever in U.S. No	If Y	s Decedent of Hies, specify Cuba	n, Mexican, Pu	(Specify Yes or No erto Rican, etc.)		American Indian, White, etc. white		
1215-0036	ithin 72 hour ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 o	r 5.1\	(Give kin	t's Usual Occup d of work done o VOT use retired)		working	16b. Kind of Busin	ess Industry		
land 21	be filed w ental Hygi ked other ic event, t	To Be	17. Father's Name (First, Middle, Last) Moses Dahan				18. Mother's l	Name (First, Middle Maknine				
	d 2 should alth and Me 27 is mari r traumati	68	19a. Informant's Name/Relationship (Type, Print) David Bennaim, Son-in-La	1 1	_			Rural Route Numb aithersbu	er, City or Town, State	e, Zip Code) 0878		
Baltimore,			20a. Method of Disposition 1	20b. Place of cemeter	Disposit y, cremat	on (Name of ory or other plac	e) 11	/47°11 morial Pa	20c. Location - Cit	y or Town, State		
salt	permit. Page Department of Important: If any injury or once.		21. Signatur Fuberal Service/Licensee	110150				Funeral				
Ī	Physician/		23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li Immediate Cause (Final disease or condition resulting in death)	ed the death. Do notine.	254 ot enter t	Carrol he mode of dyin	g, such as card	NW, Wash: diac or respiratory a	ington, DC rest,	Approximate Interval Between Onset and Death		
ممسيد	Examiner	er	Sequentially list conditions.	ary tr	act	infe	ction			days		
00	te be executed nysician and he burial-transit	Examin	cause. Enter Underlying Cause (Disease or linjury that initiated events	s a consequence o								
. Box 68/60	To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 burus after death certificate be exwithin 24 burus after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the buria	Physician/Medical		n 2 D Fetal death tat time of death		ctopic pregnand	sy		23d. Date o Month	of delivery Day Year		
IS, P.O.	uires that I n signed b	þ	Part II. Other significant conditions contributing to death	Enceph 6	4		ven in Part I.			te to the cause of death? Probably 4 Unknown		
Vital Records,	he law req tte has bee age 2 shor	Completed		farlure	liffi	cile		24a. Was auto perf	psy prio ormed? dea	e autopsy findings available r to completion of cause of th?		
tal	cian: T ertifica ector, p	Be	examiner?					Check only one)	2-E NO 1 - E	7 100 2 43 100		
10 T	ing Physi	ate: To	1 ☐ Yes 2 ☒ No Prospitati. 27. Manner of Death 1 ☒ Natural 5 ☐ Pending			28c. Injury work	4 ∐ Nursin / at ?		dence 6 Other (S	Specify)		
DIVISION OF	al or Attend s after death I Director: /	Certificate:	2	njury - At home, far etc. (Specify)	rm, street		Yes 2 □ No	28f. Location (City or To		r Rural Route Number,		
-	the Hospita nin 24 hours the Funera npleted fille	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best only one) 3 Certifying Nurse Practioner: To the	examination and/or	r investiga	tion, in my opinio	n, death occurr	red at the time, date	and place, and due to ne cause(s) and manne	the cause(s) and manner stated er as stated.		
	o a with		29b. Signature and title of certifier			29c. License		,	29d. Date signed (N			
	28h		30. Name and addless of person who completed cause of HVY D. NGUY FW, MD	death (Item 23a) (1	Type, Prin	t)	CENT	GR DRIVE	NOVEMBE F, ROCKVI	20850 LEE, MD		
	Stat Registra			trar's Signature					/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35402 State of Maryland / Department of Health and Mental Hygiene U for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Year Rose Daniello November 12 10P M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 213-20-1850 Director 1 □ M 2 🏲 F 102 Aug. 16, 1909 Maryland show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f MD Baltimore 1 X Yes 2 No 9 10e. Street and Numbe 10f. Zip Code ms 23a or must be n 10g. Citizen of What Country? Funeral 21239 1124 Walker Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Examiner Black, White, etc or þ 1 Never Married 2 Married 2 X No 1 Yes Baltimore, Maryland 21215-0036 within 72 hours after White 1 Yes 2 No Specify. 3 Nidowed 4 Divorced "natural" Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) th and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Sales Clerk Retail Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carmello Garbo Rosalie Syracuse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Daniello of Health of Item 27 1124 Walker Avenue; Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Lake View Mem. Park 11/8/2011 5 1 X Burial 2 Cremation 3 Removal from State Department of Important: If any injury or once, Sykesville, MD ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death END. Stage Dementia Ph_sician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 Unknown þ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has bage 2 s performed? death? 1 Yes Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 \(\simeg\) Yes 4 Nursing Home 5 Residence 6 Nother (Specify) and nap, 1 Hospital: Other: 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completely filled Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) mckaj spodnem. D D0057463

Registrar

State

M

5203

Baltimore MD 2120 9

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

Smil

32. Registrar's Signature

.S. Rujapakelm.D.

filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35403 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 11:47 A^M <u>Hollis</u> Roderick 30 2011 Medical Duncan 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs, last birthday) Days Hours Min (Month, Day, Year, 6/12/1939) Director 119-74-6645 Usual Residence of Decedent 1 🛛 🛣 M 2 🗆 F Tobago 72 28a-f shov 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George's Upper Marlboro 1 X Yes 2 No 10e. Street and Number 10g. Citizen of What Country? USA 10f. Zip Code Funeral 9300 Southmoor Court 20772 permit. Page 1 and 2 should be filed within 72 hours after death of pepartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2XX No Specify Specify: Black Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Certified Public Accountant Government Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ Cecil Duke Mordant Duncan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 Southmoor Ct. Upper Marlboro, MD 20772 Yvonne Duncan/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Resurrection Cemetery 11/09/2011 Clinton, MD 22. Name and Address of Facility Marshall-March Funeral 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pnysician/ a disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine tructive pulmonary disease attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has har ral director, page 2 s autopsy performed? death? 2 No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes ၉ Other: 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Injury at 28d. Describe how injury occurred 5 Pending work? 1 \(\text{Yes} Natural 2 🗌 No 2 Accident
3 Suicide
4 Homicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day,

State Registrar 31. Date filed (Month, Day, Year)

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 35404 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 25 Day Month October 2011 Anna Kay Dyott 2049 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Tulbot Easton Memorial Hospital Social Security Number 8. Date of Birth (Month, Day, May 8 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Hours 216-54-9886 1949 Mary Land **Director** 62 Usual Residence of Decedent 10a. State the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 X Yes 2 No MD Talbot Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Federal Street #26 21601 USA and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc ģ 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 0 certified nursing assistant healthcare Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Earl Thoms Dyott Mary Kathleen Fleetwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kimberly Beckhardt/daughter 28240 Kinder Road Federalsburg, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 X Donation 5 ☐ Other (Specify) Board 655 W. Baltimore Street Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sause (Final Physician/ seve or disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, cause. Enter Underlying Exami nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery atten in the past 12 month signed by the atte 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Kidney Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Tes 2 12 No Other: 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manney of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Oct, 26, 2011 Mohan

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohan

NOV 0 7 2011

219 Washington Street

00069567

Easton, Maryland 21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) NOVEMBER Day 1 20°11 Physician/ 9:59 A M Evans Aloysius Richard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE GREATER BALTIMORE MEDICAL CENTER TOWSON Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year 8-29-1923 Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** Days 1**X**XM 2 □ F Months Hours 88 193-16-8470 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2X No Lutherville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 21093 K 208 2525 Potspring Rd. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1XXYes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. EVANS, Richard Specify: White 3 Divorced 4 Divorced Completed Year or Dates WW II 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry United States Elementary/Seconday (0-12) College (1-4 or 5+) Naval Academy Professor/Library Director Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mary Frances Kelly William R. Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2525 Potspring Rd. K208 Lutherville, MD 21093 (wife) Jane Evans 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State St. Charles Cemetery | 11-5-2011 Pikesville, MD Donation 5 Qther (Specify) 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 Wayne Osterling or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. nterval Between Onset and Death Immediate Cause (rina ARD Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami and I-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): ng physician a Physician/Medical that the death certificate be P.O. Box 68760 attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Year Pregnant at time of death 5 Other (specify) the been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Nuknown Division of Vital Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No certificate the Hospital or Attending Physician: funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **N**No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral direction. 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 1 Natural 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 5 Pending 2 No Investigation Accident 3 Suicide
4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier of the revestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated owledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and 3 Certifying Nurse Practioner: To the best of my know 29b. Signature and title of certifie 30 Name and

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

within 24 hours after To the Funeral Dire

Registrar DHMH 17 Rev 1/2001

State

OCME 2006

29b. Signature and title of certifier

Russell Alexander MD.

31. Date filed (Month, Day, Year,

29c. License number

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

and manner stated

Assistant Medical Examiner

32. Registrar's Signature

ame and addre spream of the strategy and the eather temperature

29d. Date signed (Month, Day, Year)

October 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician NOVEMBER 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number, Examiner BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) Age (In yrs. last birthday) 8. Date of Birth 5. Social Security Number **Funeral** Days Hours 1 M 2 F 213-26-087 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it e Manical Examine in unit to notified at 1 Ves 2 No Director Md 10g. Citizen of What Country? 10e. Street and Number 7165 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 □Yes 2 DNo altimore, Maryland 21215-0036 2 3 ₩idowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ DAMPSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any Injury or other trau once. 904 20c. Location - City or Town, State 20a. Methed of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FORESTAND. 4 □ Donation 5 □ Other (Specify) 21. Sig a ure of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications to caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death yeals ON Cancer Immediate Cause (Final TAST ATIC **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nunsequence of) Physician/Medical Examiner attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the rector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 No 2 MNo 1 ☐ Yes 1 TYes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) æ Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manne of Death 28d. Describe how injury occurred 5 Pending investigation Hospital or Attending Division 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number P25490 NOVEMBER 4, 2011 WAMAR AVE, BACTIMORE, MD - 21229 30. Name and addrese of person who completed cause of death (Item 23a) (Type, Print) 900 5 WAM AR CATON Year, 37 Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Baby Boy Ezechukwu Medical Facility Name (if not institut)on, give street and number, 4c. County of Death Examiner Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months Director infant 1 🖾 M 2 🗆 F Yrs. 3 Oct 23, 2011 Maryland 28a-f show 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland must be notified at Director 1 Yes 2 No Anne Arundel Jessup 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö Funeral 23a 20794 7319 Wye Avenue USA or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces? Black, White, etc. þ 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No black "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) infant the infant infant infant other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lucy Ezechukwu မ be Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 21287 600 Wolfe Street Baltimore, MD The Johns Hopkins Hospital 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 5 ₩ Other (Specify) in 2Stared Adar of Board 655 W. Baltimore Street ure 1 - meral Service 21201 Baltimore, MD art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Sauce (Final Physician/ CONGEM 742 HEARLY KEECTS disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** HYDNUP. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of nding physician and use as the burial-transit PHEMATURITY Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last DISTHERS SYNDRUME Physician/Medical NESPINATORY death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year for Month Dav 5 Other (specify) 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the at Id be detached for or Attending Physician: The law requires that the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown 1 🗌 Yes Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed? death? 1 Yes 2 No this certificate 2 X No Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Hospital Other: 1 Yes 2 X No 4 Nursing Home 5 Residence 6 Other (Specify) ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? ↓ 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred s after death. I Director: After t 1 Natural injury 5 Pending 2 No Investigation Accident Suicide Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 29d. Date signed (Month, Day, Year) 29b. Signature angytitle of certifier 29c. License number

State Registrar SUSAN

KIM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

n.ES-000

OCTOBEN 26, 2011

11-07672 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

NK UNK	Certificate of Death												35409
Physician	n/	Registrar 1. Decedent's Name (First, Midd)	e,Last)							Date of De	eath Day Year	\top	3. Time of Death 1535 hrs
ledical Examin	er	John A. East 4a. Facility Name (if not institution	n give etreet and n	umbor)		b. City, To	wn orl	ocation of		October	13, 2011 4c. County of	Death	1555 HIS
		2006 N. Forest Park		umber)	1	Baltimo		ocation of	Death		To. County of	Dodin	
Funeral		5. Social Security Numberunk	6. Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under	24Hrs.	8. Date of B	Birth (MM/DD/YYYY)		
Director		GIII	1XM 2F	5	6 Yrs.	Months	Days	Hours	Min.	Jan 1	4, 1955	Foreigr Cou	ntry)
	ŀ	Usual Residence of Decedent				L							
w any	-[10a. State 10b. County		10c. City	y, Town or Locati								10d Inside City Limits 1 Yes 2 No
faryland	ğ	MD			Baltin						10 000 (1145-		11
Mary r 28a-	Director	10e. Street and Number 2006 N. Fores	t Dorle Azz	07110		10f. Zip 0		216		ļ	10g. Citizen of Wha		uy?
	<u>e</u>	11. Marital Status		cedent Ever in U	1 13 Wa	Deceden			2 / Spec	ify Yes or N			an Indian, Black,
ath w	uner	1 Never Married 2 M	arried Armed F	orces?		s, specify					White,		
fler de	٠.	3 Widowed 4 Div	1 Yes orced If Yes, Give Ye	2 X No ar	1	Yes 2	No	specify:			Specify:	W	hite
ours a	<u>و</u>	15. Decedent's Education (Spe	cify only highest gra	de completed)	16a. Decedent	s Usual 0	ccupatio	n (Give ki	nd of wor	k doneink	16b. Kind of Bus	ness/In	unk unk
D36 thin 72 h ne. than "n ledical E;		Elementary/Secondary (0-12)	College (1-4 or 5+)	T daning inc	Stor Work	ng me. L	JO 1101 G	00 1011100	•/			
5-0036 led within 7 Hygiene. I other than	Completed	unk	unk				- I 10	Mothors	Nama /E	iret Middle	, Maiden Surname)		
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Should and Mer 7 is man		19a. Informant's Name/Relations	hip (Type, Print)		- 1		,				umber, City or Town		
and 2 shou (ealth and N tem 27 is n traumatic	-	O.C.M.E.		20h	900 W Place of Disposi					t Bal	timore, M		
Baltimore, Normit. Pages I and Department of Health Important: If item injury or other trav	-	1 Burial 2 Cremation	3 Removal f		crematory or oth			,					ŕ
tim trent trent;	1	4 Donation 5 X Other 21. Signature of Funeral Service	pecify in sta	ate	22 N	amo and A	ddroes o	of Excility					
Battimore, MD permit. Pages 1 and 2 sh Department of Health and Important: If item 27 it injury or other traume.	ļ	Ronald	S. Wade	Directo							W. Baltin		Street
Physician	+	23a. Par I. Enter the disease, or	complications that	caused the deat	h. Do not enter th	e mode of	dying, s	uch as car	diac or re	espiratory a	rrest, shock, or hear	t	Approximate Interval Between Onset and
IMedical Examiner	1	failure List only one cause Immediate Cause (Final disease	77	encivo	clerotio Cardiova	scul:	er D	iseas	ie.	DISC	ase		Death
_Adminer	-	or condition resulting in death)	Due to (or as	a consequence	of):								
	<u>ا</u> ق	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as	a consequence	of):								
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cath certificate be attending physic for use as the bu		IF FEMALE: 23b. Was decedent pregnant in th		outcome of pre birth		al death	3	Ectopic p	oregnand	у	23d. Date of d Month		ay Year
x 60 th cert	S	past 12 months?		nant at time of d		er (Specia	y)						
Box te death c the atten the atten	Physic		known 9 Unkn					. i. B. d		22a Did	tobacco use contrib	uto to I	he cause of death?
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Records, The law requir icate has been s	흵									perf	formed? de	eath?	ompletion of cause of
		25. Was case referred to medica	, 			26	Place o	of Death (C	Check on		2 No 1	Ye	s 2 No
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Of Vital ling Physiciac	اء	27. Manner of Death	28a. Date	e of Injury h, Day, Year)	28b. Time of Ir	jury 28	c. Injury	at Work?	28	3d Describe	e how injury occurre	a	
ion tendii tor: A	[1 X Natural 5 Pend 2 Accident Inves		, ==,,,			1 Ye	s 2 1					
Division of Vital I Hospital or Attending Physiciae: 43 hours after death. Funeral Director: After this certified filled in by the funeral director.	Certification:	3 Suicide 6 Coul	d not be 28e. Place		home, farm, stree	t, factory,	office bui	ilding, etc	28	or Town,		or Rur	al Route Number, City
Divis Hospital or A 24 hours after Funcral Dire stely filled in b		29a. Certifier	(0,000,0)		doe death occur	ed at the t	ime date	and plac	e and du	e to the car	use(s) and manner a	as state	ed
Di To the Hospital within 24 hours a To the Funeral I completely filled	Medical		miner:On the basis	of examination	and/or investigati	on, in my	ppinion, (death occu	urred at t	he time, dat	e and place, and du	e to the	e cause(s)
To viti	Me	29b Signature and title of certifie	and manner :	SIGIEU		29c.	License	number	-		29d. Date signe	d (Mor	nth, Day, Year)
		Janute Duis	hell mi)			O.C.M	.E.			10-14-	11	
	Ì	30. Name and address of person				101 -		0.	D 111		04000		
	Ĺ	Pamela E. Southall, M		Medical Ex		W. Ball	imore	Street,	Baltim	ore, MD	21223		
Sta	S.	31. Date filed (Month, Day, Year)		egistrar's Signa	Te ban	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35410 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Year Edith G. Elliott 6:18 AM NOU Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSP 600d Baltimore Samari tan 8. Date of Birth (Month, Day, Year) 7. Age (In yrs, last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 220-38-9705 Director 71 1 □ M 2 🛛 F Aug. 6, 1940 North Carolina Usual Residence of Decedent show 10a. State 10b. County notified at 10c. City, Town or Location 10d, Inside City Limits Funeral Director 28a-f 1 Tes 2 X No MD Baltimore Parkville 10e. Street and Number r items 23a or ner must be n ō 10f. Zip Code 10g, Citizen of What Country? 8208 Oakleigh Road USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian er than "natural", or iter the Medical Examiner Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Specify: Completed white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene.
is marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education event, Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ Gibbs Garland Ella Street injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other tranonce. Ronald W. Elliott son 8208 Oakleigh Road; Parkville, MD 21234 Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vets Cem. 11/14/2011 Owings Mills, MD 21. Signature of Inneral Service Li 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Towson, MD 21204 Inc. 23a. Part 1. Enter the disease, or complete shock, or heart failure. List only one tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximate Interval Between Immediate Cause (Final nset and Death Physician/ PIra tor disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner O Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur TON Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not <u>re</u>sulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an abe autopsy performed? death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner-of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) November, a Dr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Blud Baltimore MD 21239 Abou ahv 5601 loch 32. Regi State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary C. Fleiner Year 815 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Square Hos FRANKLIU PITal LTIMORE Social Security Number If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F (Month, Day,) March 27 215 12 8038 Min. 89 **Director** Maryland Usual Residence of Decedent 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 🗌 Yes 2 🄀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 259 Nanticoke Rd. 21221 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 XWidowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Riveter Aerospace Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph George Hock Catherine Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles J. Fleiner (Son) 2011 Oakland Rd. Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gardens 11/7/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Signature of Funeral Service License 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a/Part 1. Enter the disease, or complications that caused the death. Do not enter the mode Approximate Interval Between Onset and Death nock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition Ph, sician/ Medical resulting in death) Due to (or as a con ence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a conse -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and Due to (or as a consequence resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year s been signed by the sahould be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy page performed' death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ဂ္ 1 🗌 Inpatient 2 🗗 ER/Outpatient 3 🔲 DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After atural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 Tes Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of cer 29d. Date signed (Month,

Registrar

State

31. Date filed (Month, Day, Year)

son who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

50/

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	,	For State	Plea	se Type or Pr State of N		nd / De	partm	ent of H	lealth and	e All Copie d Mental Hy		_	э.
Division		Registrar 1. Decedent's Name	e (First, Middle	, Last)			ertifica	ate of L	Jeath 	2. Date of De		2011	3512 3. Time of Death
Physicia Medi	cal		_eroy	Folks give street and number)			45.0	Mar. Towns	- L ti of Do	Month	3		1 0910 M
Examir	ner	North	west	Hospital E	R-7		46. 0		Location of De 山くかいへ		40	. County of De Balt	ath more
Funeral Director		5. Social Security Nu 215-52-23 Usual Residence of	49	6. Sex 1 ፟፟፟	ge (In yrs. i	ast birthda 1 Yrs	Mont	hs Days	If Under 24 H Hours Mi			49 9. E	Sirthplace (State or Foreign Country) Mary land
yland f show ed at	ioi	10a. State	10b. County		10c. Cit	y, Town or	Location						10d. Inside City Limits
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Page 1 nent of ant: If i		1 ☐ Burial 2 ☐ 4 ☐ Donation		3 ☐ Removal from State pecify)	e C	emetery, c	rematory o	or other place nation	· •	1/4/11	-	•	, Maryland
permit. Departr Imports any inji		21. Signature of Fun	neral Service Li	icensee			22. Name	and Addres	ss of Facility	_11824 R	eist	erstow	n Road
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Medical Examiner		resulting in death)	17	a. Due to (or as	a consequ	uen of):	, pre joe						
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be executed ician and burial-transit	al E	resulting in death) L	.ast	Due to (or as	a consequ	uence of):							
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unting the hours of Autonomy Priyacian. The law requires that the death certificate be execut within 24 hours after death. To the Funeral Directorar After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transpace.	Physician/Medio	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcome 1	2 Feta	al death	3		у			23d. Date of d Month	lelivery Day Year
gned b	<u>ا ک</u>	Part II. Other signific	cant condition	ns contributing to death	but not res	ulting in th	e underlyir	ng cause giv	en in Part I.				to the cause of death?
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in 24 hor he Fune pleted fi	Medical	(Check 2	Medical Ex	Physician: To the best of caminer: On the basis of Nurse Practioner: To the	examination	and/or inv	estigation,	in my opinio	n, death occurre	d at the time, date	and place,	, and due to the	e cause(s) and manner stated
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3x 8		So, marne and addres	Micha	tho completed cause of a	eath (Item	∠3a) (Type	orthu	ies+	Hospita	1 ER-7			
Stat Registra		31. Date filed (Month	Day, Year)	3. Registr	ar's Signat	re /	arks	,		83			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 3/ 2 Sel Leonardo Fields Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death chever If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In v rs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign 1 ★ M 2 □ F Days Months 579-56-1636 Hours 0670871943 Washington, DC Director 68 Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Prince George's txx Yes 2 ☐ No Forestville 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a on Medical Examiner must be Funeral 2912 Parkland Drive 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Divorced 4 Divorced Specify: Black Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16h Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Sew Machine Repairman Elementary/Seconday (0-12) College (1-4 or 5+) Private traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill of Health and Mental fitem 27 is marked မ Leonard Fields, Jr Vivian Rucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rolonda Fields/Wife 2912 Parkland Dr., Forestville, MD 20747 20a. Method of Disposition
1 ☐ Burial 2 【★Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 11/4/2011 Alexandria, VA Metropolitan Crematory 22. Name and Address of Facility Marshall-March Funeral Home Funeral Service Licenses 4308 Suitland Road Suitland, MD 20746 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph sician/ Onset and Death 6 unshot Wound to disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of). that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be exect within 24 hours after death.

To the Funeral Director: After this confidence. resulting in death) Last Due to (or as a consequence of): use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 signed by the attending the detached for use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Shot Alans el Tin Read 28c. Injury at injury 1624M October 31, 201 1 🗌 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide determined building, etc. (Specify) Lon Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Intedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35414 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct. Loretta 2011 Frye 4:45 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 9108 Cove Point Road Edgemere Baltimore Co. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 213-28-6334 **Director** 1 □ M 2 X F Yrs 80 Jan. 23,1931 Maryland show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 Ves 2 No MDBaltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9108 Cove Point Road 21219 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 □ Divorced If Yes, Give White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Years College (1-4 or 5+) Crossing Guard Baltimore County Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Margaret J. McDermott Samuel T. Gibson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 381 Valley View Drive Swanton, MD 21561 Margaret J. Crawford (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗷 Burial 2 🗆 Cremation 3 🗀 Removal from State Sacred Ht. of Jesus Cem.11/2/2011 Dundalk, Maryland 4 Donation 5 Other (Specify) 21. Signatur of uneral Serv Duda-Ruck Funeral Home of Dundalk, Inc. Dun dalk, Maryland 7922 Wise Ave. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ obstructive almonary Chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner abu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examine Due to for as a consequence of use as the burial-transi attending physician and Due to (or as a consequence of): resulting in death) Last IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Radianopathy 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an macular degeneration certificate has performed?

1 Yes 2 No death? 1 ☐ Yes 2 ☐ No al or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🕱 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? X Natural 5 Pending injury Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🗵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. Box 68760 ours after death.

eral Director: After this certifice filled in by the funeral director, within 24 hours a

To the Funeral C

completely filled the Hospital

> State Registrar

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(Month, Day, Year)

(Check

Colgate 32. Redistrar's Signature

MD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

title of certifier (

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29c. License number

Certifying Nurse, Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 12:10 Physician -RANCES 04 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE Co PARKWAY CENTER BALTIMORE enesis Perrino Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 07/24/1920 6. Sex Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 ☑ F MD 213-16-4798 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Marical Exprimer must be neutified at once. 1 ☐ Yes 2 ☑ No **Funeral Director** MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3119 Northway Drive 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [X] No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No þ Specify. 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Home Maker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Harry Hall Sarah <u>Elizabeth</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3121 Northway Drive, Baltimore, MD John Metheny, Friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 11/08/11 Gardens of Faith 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Sepandra 5305 Harford Road. Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final EN T EM 10 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Due to (or as a consequence of): Physician/Medical IF FEMALE: To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 □ Yes 2 🔣 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 Hnapolsh R15217

DHMH 17 Rev 1/2001

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State Registrar 6095 Marshalee Dr. ElkraDGE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

ERSC ANAPOLSKY

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #26 Per PHY G921 11/07/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 9:304 DRIS JOV SAMBER 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 1045 Hignet Way N/C Baltimore City If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday 6. Sex **Funeral** Min. Hours Months Days 1 □ M 2 🔀 F Yrs Feb. 9,1918 Maryland 93 Director 220-82-9877 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location r 28a-f show notified at 10a. State 10b. County 1 XYes 2 □ No Baltimore City Director MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or pe United States 21205 1036 Hignet Way "natural", or items 23/ edical Examiner must Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify þ ₩idowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker <u>Own Home</u> 8 Years n and Mental Hygie permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If Item 27 Is marked other any injury or other traumatic event, I 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gertrude Hill Brodsky Η. Schy ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7 Hanford Drive Harmans, Maryland Mildred E. Bileck (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Moreland Memorial Park 11/7/11 Baltimore, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. ureral Service Live 21. Signature 7922 Wise Ave. Dundalk, Maryland 21222 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final YEARS DEBILIT Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner EMENTIN Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,公 Due to (or as a consequence of) physician Physician/Medical attending physic for use as the b 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the a 9☐ Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1□ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 3 Ansidence 6XX ther (Specify Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After 1 Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. n 24 hours after death.

ne Funeral Director: A pletely filled in by the fi 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2, To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JÈNNIFER HAYASHI **化系**条 5505 Hopkins Bayview Circle, Balt., MD 21224 32. Registrar's Signature 31. Date filed (Month, Day, Year) State NOV 0 Registrar

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	Funeral	-	FUTURECARE CHES 5. Social Security Number		e (In yrs. last birtho		REISTE nder 1 Year	RSTOWN If Under 24 Hi	S. 8. Date of Bir		TIMORI	lace (State or Foreign
	Director		212-12-9789	1 □ M 2 🕅 F	Y	Mont		Hours Mi	n. (Month, Da	y, Year)	Count	'ry)
	bow at	Ļ	Usual Residence of Decedent 10a, State 10b, County		95 10c. City, Town of				10/05	/1916	1.	MD Od. Inside City Limits
	farylar 8a-f s tified	Director	MD N/A		BALTI						"	1 X Yes 2 □ No
	a or 2 be no		10e. Street and Number		24111111		Zip Code		T	10g. Citizen of	What Coun	try?
	th with ms 23 must	Funeral	333 EAST 30TH				21218			-		USA
(0	er dea or iter niner	by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Marr	12. Was Decedent in Armed Forces?	Ever in U.S.	If Yes, s	pecify Cubar	n, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ce - America ick, White, e	
993	ırs aftı ural", I Exar	ted k	3 X Widowed 4 Divorced	If Yes, Give Year or Dates.	110	1 \sum Yes	s 2 🕅 No	Specify:		Specif	WHIT	ΓE
15-(72 hou n "nat	Completed	15. Deceden (Specify only highe	t's Education st grade completed)	(0	live kind of		ation Juring most of w	orking	16b. Kind of E	Business/Inc	lustry
212	within giene.		Elementary/Secondary (0-12)	College (1-4 or 5	5+)	e. DO NOT	use retired) HOMEM	AKER			OWN HO)ME
nd	tal Hyg	o Be	17. Father's Name (First, Middle, La	ast)					ame (First, Middle,	Maiden Surnam	ne)	
ryla	uld be d Men marke natic	고	KALMAN		OGUR			MOLLI			PATYK	
Ma	12 shouth and 27 is urtraur	- 1	19a. Informant's Name/Relationsh ARLENE OGURICK						Rural Route Numbe			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatte event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation		20b. Place of D	isposition (*	Name of		Date	20c. Location		
tim	t. Page tment tant; I		4 Donation 5 Other (S	pecify)	BETH" HAGOD	HAMED OL CO	or other place ROSH NG -	11/	04/2011		DALE,	
Ba	permit Depar Impor any in		21. Sign ture of Funeral Service U	Muse-		22. Name	and Address	s of Facility S	OL LEVINS N ROAD, 1			
	Ph sician/ Medical Examiner	ı	23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	_a End	the death. Do not	enter the m	ode of dying					Approximate Interval Between Onset and Death
	be e siciar buri	edical Examiner	if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of):							
). Box 6876	I he law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death	3	ic pregnancy (specify)	,			ate of deliver	ry Day Year
ds, P.O.	quires that en signed k buld be det	ρ	Part II. Other significant condition	ns contributing to death b	ut not resulting in t	ne underlyin	g cause give	en in Part I.				e cause of death? ably 4 🗆 Unknown
DIVISION OF VITAL Records,	law has le 2	Completed							24a. Was a autop perfor 1 Yes	sy med?/		sy findings available apletion of cause of
Ita	stcian certifi irectol	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othor	ce of Death (Che				
0	g Phy er this neral d	te: To	27. Manner of Death	28a. Date of injur		e of	DOA 28c. Injury	4 Mursing	Home 5 Resid			
0	rendin leath. or: Aft the fu	ifica	1 Natural 5 Pending 2 Accident Investiga 3 Suicide 6 Could no	ation	; Year) inju	M	work? 1 □ Y	′es 2□No				
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:	Fune Fune etely f	Medical	(Uneck 2 L. Medical Ex	Physician: To the best of aminer: On the basis of ex	amination and/or in	vestigation, i	in my opinion	death occurred	at the time date ar	nd place and du	a to the cour	a(e) and manner stated
	vithin To the		only one) 3 L Certifying N 29b. Signature and title of certifier NS Rayapax	Nurse Practitioner: To the	best of my knowled		9c. License r			29d. Date signe		
		- 1	30. Name and address of person with S. Raja pa	no completed cause of de	28355	milh	ßv	S 7 03	Bald	imere	· M	751509
	State Registra	e r	1. Date filed (Month, Day, Year)	32. Registra	r's Signature	ne 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 35418 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Garr Month Year 18-35 M Yovember 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town or Location of Death 4c. County of Death Counts toward Howard Creneral Hosnul Columbis Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov 8 Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏲 F Days 180-12-4558 95 Ý1915 Pennsylvania **Director** Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 X No MD Howard Ellicott City ō 10e. Street and Number 10g. Citizen of What Country? ms 23a o must be Funeral 2500 Kensington Garden #107 USA 21043 Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. White 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed 3 XWidowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Carr Mary (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Garry, Jr. Son 2500 Kensington Garden #107; Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or Loudon Park Cemetery 11/7/2011 Baltimore, MD Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke ignature of Funeral Service Livense Funeral Home of Catonsville, In 1630 Edmondson Avenue: Catonsvi 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death myo cardial Immediate Cause (Final Ph. sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a conseque Stenosis attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Year Dav Pregnant at time of death signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate has 2 🗌 No 1 Yes Physician: 25. Was case referred to medica completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Hospita 2. No Other: မ ER/Outpatient 3 DOA Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this Date of injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural injury 5 Pending after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D30641 November 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Back 201-109 abay

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Graham 20**1**1 Seu Mee 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Northhampton Frederick Frederick If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 □ **X**F Months Hours Jan^{nth,} 30 ^y1931 80 212-42-2364 China **Director** Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Yes 2 XNo Marvland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 21701 200 East 16th Street U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14, Race - American Indian, Armed Force 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: Asian 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, permit. Page 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other transmits. Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Owner Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Foon Lei Lui Ngan Hang Lee Lui 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9621 Windermere Turn Ft. Washington, Md. 20744 Seu Fong Lim / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Md.Vets.Cem-Crownsville 11/8/2011 Crownsville, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRuck Towson Funeral Home, Signature of Fur Signature Lin 1050 York Road Towson, Maryland 23a. Part 1. Enter the disease, or complia tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Immediate Cause (Final Onset and Death Dementio Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to jor as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours at er death.

To the Funeral Director. After this certificate has completed filled it by the funeral director, page 2. autopsy performe Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျှ 1 Inpatient 2 I ER/Outpatient 3 I DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide Medical Extifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of phyknowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mp

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar 35420 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 8:48 AM Giles Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins N/A Balt more Hospital Cit 217-34-6686 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign (Month, Day, Year) Director 1 □ M 2 🗓 F 73 11/27/1937 N. Carolina 28a-f show with the Maryland 10a. State 10h. County 10c. City, Town or Location must be notified at 10d. Inside City Limits Director N/A 1 X Yes 2 No MD Baltimore 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2409 Westwood Ave. 21216 U.S.A. Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. P þ 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Completed "natural" 3 Widowed 4 Divorced Specify: Black Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) h and Mental Hygiene.
T is marked other than traumatic event, the Me Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Laundry Laundry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rufus Pear Mary Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Chlorice Hilliard (daughter 5315 East Dr., Arbutus, MD 21229 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Zion Cemetery11/05/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Funeral Home PA Baltimore, MD 21217 2JUSephdrff of Fabrown Jr. 2140 N. Fulton Ave., camo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Cerebra disease or condition resulting in death) HICXIC Medical Due to or as a consequence of) Examiner Electrica Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami Palmenory Ity Mertension and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Vear ate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has autopsy performed' 1 Yes 2 No Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 🔲 Yes 2 🗌 No Accident Investigation Funeral Director: 2 ☐ Acciden
3 ☐ Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after determined 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 24 (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number

Registrar

State

Mr - Loyed to ME for

WOILE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 N.

32. Registrar's Signature

Itousten

31. Date filed (Month, Day, Year)

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Balti More

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villie Harris	1- For State Certificate of Death Reg. No.										
Physician/ Medical Examiner	1. Decedent's Name (First, Midd Willie		arris				2. Date of Dea Month Novembe	ith	3. Time of Death 1046 hrs		
	4a. Facility Name (if not institution Harbor Hospital Cente		r)	4	b. City, Town, or L Baltimore	ocation of Dea		4c. County of	of Death		
Funeral Director	5. Social Security Number 218 – 86 – 9191	6. Sex 7. A	ge (In yrs. last birl	hday) Yrs.	If Under 1 Year Months Days	If Under 24H Hours Mi	_	th(MM/DD/YYYY) 6-66	9. Birthplace (State or Foreign Country) MD		
any	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Locatio	n				10d. Inside City Limits		
	MD N	ΙA	Bal	timo	ore				1 Yes 2 No		
Maryl r 28a-1 ed at o	10e. Street and Number				10f. Zip Code		1	0g. Citizen of Wha			
with the Maryland ns 23a or 28a-f sho be notified at once. sral Director	703 Lyndhurs	t Street 12. Was Deceder	nt Ever in II S	13 Was	2122 Decedent of Hisp		Specify Vos or No	USA	- American Indian, Black,		
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21214 ould be fil d Mental F s marked fic event, I	Willie 19a. Informant's Name/Relations	Harris,		Mailing	Address (Street	Jean	Rural Route Num	Harris	ı, State, Zip Code)		
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: If tem 27 is in injury or other traumatic. TG	Rickey Phais		7	03	Lyndhur	st St			e, MD 21229		
Baltimore, MD cernit. Pages 1 and 2 sho Department of Health and Important: If Icen 27 is nijury or other traumati	20a. Method of Disposition 1 XBurial 2 Cremation	3 Removal from S	20b. Place of cremate	f Dispositi ory or othe	on (Name of ceme er place)	etery,	Date	20c. Location - 0	City or Town, State		
fim (i. Page rument ritant:	4 Donation 5 Other Sp		Mt. 2						downe, MD		
Balti permit. Departm Imports injury o	21 Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home 638 N. Gilmor Street Baltimore, N										
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/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Due to (or as a cons		embo	lism				Death		
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60, cate be execu hysician and e bunial - tra	IF FEMALE:	23c. If yes, outco		т ще	,8322 12	-20-11	SIII	23d. Date of d	Helivery		
Division of Vital Records, P.O. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bedical Certification: To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 Live birth	t time of death 5	=	I death 3 [Ectopic pregn	ancy	Month	Day Year		
P.O. I s that the gned by the detache	Part II. Other significant condition	ons contributing to deat	th but not resulting	in the und	derlying cause giv	en in Part I.			oute to the cause of death?		
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of Vital Records, og Physician: The law require ufter this certificate has been si neral director, page 2 should b 1: To Be Completed	25. Was case referred to medical				26.Place o	f Death (Check	1 ✓ Yes :	2 No 1 e	Yes 2 No		
Physici r this or al direc	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpatio			0071		ng Home 5		Other:		
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Divisior Bospital or Attend 24 hours after death. Funeral Director: etely filled in by the											
To the Hos within 24 h To the Fur completely	(Check only one) 2 Medical Exam	ysician: To the best of m niner:On the basis of exa and manner stated.			n, in my opinion, o	leath occurred					
	29b. Signature and title of certifier	11	6	4)	29c. License r			November 3	d (Month, Day, Year) 3, 2011		
Ø	 Name and address of person values and Alexander MD. 			900 W	/. Baltimore S	treet, Baltir	nore, MD 212	223			
State Registrar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signature	,			2-0-0				
DHMH 17 Rev 1/2001		Line 15.	ORI	GINAL	 -			00	OME		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ October. Hutchinson 19:45 Nashica 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Suburban Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 🗆 M 2 💢 F Months July 8, 1978 Missouri Director 577-04-8580 33 Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 🗆 Yes 2 😾 No Silver Spring MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20910 IISA 8560 2nd Avenue #520 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. black Completed 3 Divorced 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) uth and Mental Hygiene.
27 is marked other than "I
r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) asst manager jewelers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Inportant: If item 27 is marked any injury or other traumatic eve once. 2 James H. Hutchinson Jr Mattie Leola Eason 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4122 Southway lane #46 Triangle, VA 22172 Vivian Gilson/aunt Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Gremation 3 Removal from State 4 Donation 5 Other (Specify) in state cemetery, crematory or other place) of Funeral Service State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ Dev ticemia disease or condition Medical resulting in death) Due to (or as **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or Injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 **E** ⊎nknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner?
1 ☐ Yes 2 🗹 No Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 DOA မ 28a. Date of injury (Month, Day, Year) completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 the only one

State Registrar 29b. Signature and title of

Rohetta Pay, Year

30. Name and addres

tutchinson, Washica

erson who completed cause of death (Item 23a) (Type, Print)

8600 01d 32. Registrar's Signatur 29c. License number

Georgetonn Rd. Bethesda

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		State of Maryland / Department of Health and Mental Hygiene											
			State Registrar			Cer	tificate of l	Death		Reg. No. 2011 354			
Physi Me	cian dica	ı .	Decedent's Name (First, Middle,	Freder		Thomas	Harris		2. Date of De Month Nov •	Dav	Year 011	3. Time of Death 4:15 A M	
Exar	nine	r	4a. Facility Name (if not institution, of 422 Trimble Ro		7)		4b. City, Town, o	r Location of Death	1	4c. County Harf			
Funer Direct	_		5. Social Security Number 217–40–1871 Usual Residence of Decedent	V-V	Age (In yrs. 67	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da May 8	th ly, Year) 1944	9. Birthp Count Mary	olace (State or Foreign try) Land	
yland -f show ed at		cto	10a. State 10b. County		10c. Cit	ty, Town or Loc	ation	T			1	0d. Inside City Limits	
the Mar or 28a e notifi		Funeral Director	MD Harf 10e. Street and Number	ord			10f. Zip Code	Joppa		10g. Citizen of W	/hat Coun	1 🗆 Yes 2 🛣 No	
with is 23a		ے ا ا	422 Trimble R	load			21	1085		United	State	es	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	3	ted by Ful	11. Marital Status 1 ☐ Never Married 2 🖾 Marrie 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceder Armed Forces 1 12 Yes 2 If Yes, Give Year or Dates	s? □ No	If	/as Decedent of H Yes, specify Cuba ☐ Yes 2 🌁 No	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
21215-0036 within 72 hours after gjene. In the medical Exami, o.; the Medical Exami		Completed by	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12 Years	's Education t grade completed) College (1-4 o	r 5+)	(Give k life. DC	NOT use retired)	eation during most of word gineer Te		16b. Kind of Bu United Governm	Stat		
and be filed ental Hy ked oth c event		10 De	7. Father's Name (First, Middle, Las George Howar	,	Sr.					Maiden Surname, ne Eckes			
Maryland 2 should be filed th and Mental Hy 27 is marked oth traumatic event			19a. Informant's Name/Relationship Mrs. Irene F.	o (Type, Print)		19b. Mailin 422	g Address (Street a Γ rimble l	and Number or Rui		r, City or Town, St		ode)	
Baltimore, permit. Page 1 and Department of Heal important: If item 3 any injury or other	,	1	0a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3	3 ☐ Removal from Sta	20b. F	Place of Dispos cemetery, crem	atory or other plac		Date	20c. Location -	•	wn, State aryland	
Baltir Permit. Pe Departme Importan	once.	1	4 Donation 5 Other (Special Service Lice)		7 /	Di Bi	Name artick	sFuneral	Home of	Dunda1k	, In	с.	
		1	23a. Part 1. Enter the disease, or co	omplications that caus	ed the deat	th. Do not enter	922 Wise the mode of dyin	Ave. Dur g, such as cardiac	dalk, M or respiratory ar	aryland rest,	212	22 Approximate	
Ph siciar Medica Examine	al	- 1	eheck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (o	s a consequ	ophic unce of):	Latera	6 Scle	r0515			Interval Between Onset and Death Months	
	Jiner		Sequentially list conditions,	b. Dys	shage	uence of):		-	_				
certificate be executed nding physician and use as the burial-transit	dical Examiner	Tool Eva	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	s a consequ	uence of):							
6876 certificate nding phy use as th	Med	-	F FEMALE:					-					
Box deeth	Physician/Me	2	3b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcom 1 Live Birth 4 Pregnant g Unknowr	n 2 ☐ Feta : at time of c	al death 3 🔲	Ectopic pregnand Other (specify)	ry		23d. Date Mon	e of delive th	ry Day Year	
ords, P.O. Be requires that the de been signed by the should be detached			art II. Other significant conditions	s contributing to death	but not res	sulting in the un	derlying cause giv	ven in Part I.		obacco use contril		e cause of death?	
Division of Vital Records, P.O. To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detach	Completed by									rmęd? pi	ere autoprior to coneath?	sy findings available inpletion of cause of	
cian: certifica	a	2	5. Was case referred to medical examiner?	Hospital:				ace of Death (Chec		220110	_ 100		
Physical chiral	12		1 Yes 2 No 7. Manner of Death	1 Inpa		ER/Outpatient 28b. Time of	3 DOA Othe	4 Nursing H		lence 6 🗆 Other			
on C anding sath. or: After	ficate		1 Natural 5 Pending 2 Accident Investigat	(Month, D	ay, Year)	injury	work'		28d. Describe n	ow injury occurred	1		
Division or Atternormal Directored in Directored in by t	Certificate:		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Ir	ijury - At ho tc. (Specify,		et, factory, office		28f. Location (S City or Tow	itreet and Number n, State)	or Rural I	Route Number,	
Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certific completely filled in by the funeral director.	Medical	2	(Check 2 \(\subseteq \text{Medical Exa} \)	hysician: To the best of aminer: On the basis of urse Practitioner: To the basis of	examination	n and/or investic	ation. in my opinio	 n. death occurred a 	t the time date a	nd place and due	to the caus	ce/s) and manner stated	
To the with To the com			b. Signature and title of certifier	e Linde	•••		29c. License	number		29d. Date signed	(Month, D	ay, Year)	
12+1			D. Name and address of person who Stephanie	o completed cause of	death (Item	23a) (Type, Pri	nt) -,11 Rd	Jor	pa, 1	40 21	085	-2,2011	
St Regist	ate rar	3	1. Date NOV 0 7 2011	Server 32. Regist	rar's Signat								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month OCT 2:12 PM 25 SONYA DAWN JORDAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death WRNMMC BETHESDA MONTGOMERY Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 □**X** Months Hours Director Yrs 06-04-1977 SOUTH KOREA 242-33-1886 34 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director 28a-f 1 Yes 2 No VA STAFFORD STAFFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a FRANCIS CT. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ò 1 X Never Married 2 ☐ Married þ Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2X No Specify: "natural", Specify: WHITE 3 - Widowed 4 - Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working "Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME and Mental Hygie is marked other Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. THOMAS JORDAN JONG PARK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCIS CT. STAFFORD, VIRGINIA 22554 THOMAS JORDAN - FATHER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town. State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) 11-04-2011 STAFFORD, VIRGINIA STAFFORD MEMORIAL PARK 21. Sign are of uneral Service Lice 22. Name and Address of Facility 9 MOUNTCASTLE TURCH FUNERAL HOME, 4143 DALE BLVD.V 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition NERVE SHEATH TUMOR Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physiciar Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) ped sign**e**d by tl d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed' certificate 2 🗌 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical director. Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 **X**No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X Natural 5 Pending work?
1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 24489 (NE)

DHMH 17 Rev 7/2009

State

Registrar

WRNMMC

BETHESDA MD 20889-5600

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CPT MC USA

32. Registrar's Signature

DOUGLAS F. POWELL

Date filed (Month, Day, Year)

NOV 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month CA 9:05 P M Selma Rose Joyner Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Doctor's Community Hospital Lanham 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yes Sept 26, **Funeral** 9. Birthplace (State or Foreign Hours 1 M 2 X Director North Carolina 237-24-5501 Sept 1922 89 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. and Mental Hygiene. 'is marked other than "natural", or items 23a or 28a-f shov raumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Prince George's Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20742 USA 3905 70th Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 X Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife own home 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Julian Dixon William Henry Rose 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zic Code) 117 Spring Place Way Annapolis, MD 21401 Bonnie DRapper/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 X Donation of inera Signatu Tate Anatomy Board 655 W. Baltimore Street Baltimore, MD nter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Year Pregnant at time of death Month Day 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Gunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform 2 1 1 Yes 2 No I ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) ည 1 🗌 Yes 2 100 Other: 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of D 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Chatural work 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MDD 58182 30. Name and add as of person who completed cause of death (Item 23a) (Type, Print) 7500 Hanover Parkway, Suito 101A, Greenbelt, MD. 2010

Registrar

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Marylar				1ental Hyg	iene	1 251.26
		Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of D	eatn	2. Date of Deat	leg. No.C. U	1 35426
Physiciar Medic		William Jackson					Month		3. Time of Death 7:30 A M
Examine		4a. Facility Name (if not institution, give str	O		4b. City, Town, or	Location of Death		4c. County of I	_
n.d.P		Esther's Place 5. Social Security Number 6. Sex	Pinewood 7. Age (In yrs.)	last birth day	Balfo If Under 1 Year	If Under 24 Hrs.	0 D-t (D) II	Balt	
Funeral Director			M 2 □ F 7. Age (m y/s.)	Yrs.	Months Days	Hours Min.	8. Date of Birth		Birthplace (State or Fbreign Mary) Land
d t		Usual Residence of Decedent 10a. State 10b. County	100 0	. Taum and a					
arylan a-f sh fied a	앓		Toc. Cit	y, Town or Loc					10d. Inside City Limits
the M or 28 e not	١	MD 10e. Street and Number	<u>-</u>	Baltin	101 e 10f. Zip Code			l 0g. Citizen of Wha	
s 23a sust b	Funeral Director	2802 Pinewood Av	enue		2.3	1224		USA	,
			2. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🕅 No	S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
al", or	ğ Q	1 Never Married 2 Married 3 WWidowed 4 Divorced	1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates.		☐ Yes 2 🏋 No		,	Specify: 1	
Z15-0U36 in 72 hours after han "natural", o Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade	ation		ent's Usual Occupa			16b. Kind of Busin	ess Industry un
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d Z ed with Hygier other i	Bec	10 17. Father's Name (First, Middle, Last)	0		mover unk l		(F) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		unk
Yiand Id be filed Mental Hy harked oth	╒│	The autor of value (1 mai, middle, 2009)				18. Mother's Name	e (FIFST, MIIOOIE, IV	iaiden Surname)	unk
and and sum sum sum sum sum sum sum sum sum sum	ı	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailin	g Address (Street ar	nd Number or Rura	Route Number,	City or Town, State	, Zip Code)
1 and 2 s of Health of Health item 27		Esther's Place			Pinewood	Avenue l	Baltimor	e, MD 2	1224
Page 1 an nent of Hannert of Hann		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State		sition (Name of atory or other place) [ate	20c. Location - City	y or Town, State
baltimor permit. Page 1 Department of Important: If is any injury or o	-	4 Donation 5 Other (Specify)	in state	20	None and Address				
Dair permit. Departr Imports any injt	-	21. Sig ature Euneral Service I censee	of pirector		tate Anat altimore,	omy Board MD 2120	1 655 W.	Baltimo	re Street
		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused the deat	n. Do not ente	r the mode of dying	, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
Physician/	1	Immediate Cause (Final disease or condition	aspirat	ion	preu	nonia			Onset and Death
Medical Examiner		resulting in death)	Due to (+ as a consequ	ence of):					2
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atth certifica attending p		ob: was accessing program	. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta					23d. Date of	delivery
death he atte	riysiciali/me	in the past 12 months? 1 ☐ Yes 2 ▶ No	4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
that the dended by the adetached		9 ☐ Unknown Part II. Other significant conditions contri	buting to death but not res	ulting in the ur	derlying cause give	n in Part I.	23e Did tob	acco use centribut	e to the cause of death?
The law requires the sate has been signed page 2 should be d	<u></u>	A-fib, CAD, CI			,g g				Probably 4 Unknown
aw require			,				24a. Was an		autopsy findings available
The la	5						autopsy perform	ned? deatl	to completion of cause of h? Yes 2 \sum No
cian; ertific ector,	B 2	25. Was case referred to medical examiner?	pital:			ce of Death (Check			100 2 2 110
Physi this c		1 Yes 2 No Hos	1 Inpatient 2 28a. Date of injury	ER/Outpatient	3 DOA Other	4 ☐ Nursing Hor			pecify) Assisted living
ath. :: After	Calc	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	work?	es 2 🗆 No	8d. Describe hov	w injury occurred	
or Attending P after death. Director: After t in by the funera	5	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At hor building, etc. (Specify)		et, factory, office	2			Rural Route Number,
pital o			<u> </u>				City or Town,		- 1.1
To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certific completed filled in by the funeral director. Modical Certificator: To Bo		(Check 2 Medical Examiner:	n: To the best of my knowle On the basis of examination	and/or investig	ation, in my opinion.	death occurred at t	he time date and	I place and due to t	he cause(s) and manner stated
To th withir To th		9b. Signature and title of certifier	The state of the s		29c. License r			d. Date signed (Mo	
		Millarca	P		R16	2291		10/19	12011
	- 3	0. Name and address of person who comp	Jeted cause of death (Item 4940 G 32. Registrar's Signate	23a) (Type, Pr	int)	2		10 210	244
State	3	1. Date filed (Month, Day, Year)	32. Registrar's Signatur	ire /	Hue 1	Daltim	ve M	10 212	24
Registrar		NOV 0 7 2011	Denogra B.	gare					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month | Physician/ Day 03 Komaine 2011 10:40 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SINAI HOSPITAL OF BALTIMORE BALTIMORE Funeral Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 214,44.270 1 □ M 2 🗙 F Hours Country) MD (Month, Day, Director حام) Yrs. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral USA Avenue Mondaymon 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 3 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: "natural", Specify: Black Completed 3 Widowed 4 Divorced Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education 12th grade sista 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis J. SMallybox Bernice Sutten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Angela Miller-King White Chapel Road Baltimore MD 21215 Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Windsor Mill, King Memorial Durk 4 Donation 5 Other (Specify) Greens Fundral Services 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vallann Road Randallstown MD 21133 23a. Part 1. F ter t e disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, o hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cac e final disease or condition Physician EPSIS Medical resulting in death) Due to (or as a consequence of): 1 month Examiner Colitis hronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit ESPIRATORY Hospital or Attending Physician: The law requires that the death certificate be executed AIMRE that initiated events Due to (or as a consequence of): Chronic Dostructive resulting in death) Last Disease. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death Yes 2 X No by the 9 Unknown be detached 9 Unknown P.O. Part I/ Other significant conditions contributing to death but not resulting in the underlying cayse given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, vascula diseans 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy certificate within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🗌 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify, 2 📉 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M.D 03 201 and address of person who completed cause of death (Item 23a) (Type, Print) O. EMURON HOSPITAL DENNIS OF BALTIMORE, 2401 W. BELVEDERF NE, MB 21215 31. Date filed (Month, Day, Year)

NOV 0 7 2011 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Samuel Kalman KAPLAN November 4 2011 6:45 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 12 **Funeral** 9. Birthplace (State or Foreign 1 X M 2 □ F Months Days Hours Min. Director 1939 Washington, <u>577-58-99</u>33 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 x No Maryland Montgomery Potomac ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 12009 Titian Way 20854 United States items 2 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. \$ 1 Never Married 2 Married ☐ Yes 2 💢 No Yes, Give Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 I th and Mental Hygiene. ?7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) the Orthodontist Orthodontia Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Albert Kaplan Minnie Reznick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 12009 Titian Way, Potomac, MD 20854 Marian DeAngelo, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit, Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Judean Memorial Gardens 11/7/11 Olney, MD Torchinsky Hebrew Funeral Home 254 NW Washington DC 20012 Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. F ter the disease. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or so a consequence of): If tray, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day 5 Other (specify) 9 Unknown the 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: ျပ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident Investigation 1 🗌 Yes 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of pertifie 29d. Date signed (Month, Day, Year) D35168 Linda A. Benson, M.D. 32. Registrars Signature

DHMH 17 Rev 7/2009

State Registrar

68760

Box

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Certificate of Death Reg. N2 0 1 1 35429											
		-	Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate or L	<i>Jeann</i>	2. Date of Dear	th	3. Time of Death				
	Physicia Medic		Josephine D. Kell	er				Month November	3. 2011	17:40 M				
	Examir		4a. Facility Name (if not institution, give si	reet and number)		4b. City, Town, or			4c. County of	Death				
manus de la companya		м	Somerford Place 5. Social Security Number 6. Sex	7 4-4 40	une de se la finite de la la	Columi If Under 1 Year		dro Lo Data (Dist	Howar					
-	Funeral Director		000 07 7/01	IM O MIC	rs. last birthday) Yrs.	Months Days		in. (Month, Day,	Year)	Birthplace (State or Foreign Country)				
	D WO		Usual Residence of Decedent	9	4			Nov. 10	, 1916 M	Maryland				
	a-f sh iied a	Director	10a. State 10b. County MD Baltin		. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 🕱 No				
	or 28		10e. Street and Number	1016	Catons	10f. Zip Code		1.	10g. Citizen of Wha					
	s 23a ust b	Funeral	317 Harlem Lane			212	28		USA	USA				
	death item	Fun		2. Was Decedent Ever in Armed Forces?		Vas Decedent of His f Yes, specify Cubar	spanic Origin?	(Specify Yes or No- erto Rican, etc.)		14. Race - American Indian, Black, White, etc.				
36	al", or	d by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 No If Yes, Give		☐ Yes 2 🔀 No			Specify:	771 4 .				
9	natur lical E	Completed	15. Decedent's Edu	Year or Dates.		lent's Usual Occupa			16b. Kind of Busin					
21	nin 72 ne. han "	omp	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	(Give F	kind of work done d O NOT use retired)	uring most of w	vorking		,				
121	dygier ther t	Be C	12 17. Father's Name (First, Middle, Last)		Homen	naker			Own Home	e				
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	To E	Francis Sczepucha				Magde1	Maiden Surname) nick						
ary	hould and M is mar		19a. Informant's Name/Relationship (Type		g Address (Street a			e, Zip Code)						
	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic		Josephine Frazier	Daughter	317	Harlem L	ane; Ca	tonsville	, MD 2122	28				
Baltimore,	ge 1 a		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	emoval from State		natory or other place		i	20c. Location - Cit					
ij	permit. Page 1 a Department of I Important; If it any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. (ign tur of Funeral Service Licersee	A		Cremator:		./8/2011 erling As	Glen Bur hton Schw					
B	permit Depar Impor any in		To anali	ome of	Catonsvil	le, Inc.	wab Witzke							
			23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only one	cations that caused the c	leath. Do not ente	r the mode of dying	, such as card	iac or respiratory arre	st,	Approximate Interval Between				
	hysician/		Immediate Cause (Final disease or condition	Atheros	clerosis					Onset and Death				
3	Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):									
		ner	Sequentially list conditions, if any, leading to immediate	Due to (or as a cons	sequence of):									
(A)	ured nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							-				
טט	cate be executed physician and sthe burial-transit	al E	resulting in death) Last	Due to (or as a cons	sequence of):									
Box 68760	cate b physi s the b	edical	d	-			<u>-</u>							
89	certifi anding use a	N/UE	Zob. Was acocacht programt	c. If yes, outcome of pre		le			23d. Date o	of delivery				
B 0	requires that the death certific, been signed by the attending p. should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time 9 Unknown		Other (specify)	<i>y</i>		Month	Day Year				
P.O.	at the d by t detach		9 ☐ Unknown Part II. Other significant conditions confi		resulting in the u	nderlying cause give	en in Part I.	23e Did tob	pacco use contribu	te to the cause of death?				
ů.	Ilres th signe Id be o	d by	Congestive Hear		3	, 3 3				Probably 4 Unknown				
ord	v requ	olete	History of cere	bral infar	ction			24a. Was ar		e autopsy findings available				
Rec	'sictan: The law r s certificate has b lirector, page 2 s	Completed						autopsperforr1 ☐ Yes	med? deat	r to completion of cause of th? Yes 2 🔼 No				
<u> </u>	ertifică ector,	Be	25. Was case referred to medical examiner?		=======================================	26. Pla	ce of Death (C		2 110	1100 2 2 110				
<u> </u>	Physic this c	ျှ	1 Yes 2 XNo		ER/Outpatien		4 LJ Nursing			SpecifyAssisted Living				
0 0	th. : After e fune	cate	27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred LIV1 28d. Describe how injury occurred 28d. Describe how injury o											
Division of Vital Records,	• Atter er dea • ector by th	Certificate:	3 Suicide 6 Could not be 4 Homicide determined determined building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num. City or Town, State)											
2	ontal or urs aft ral Dii illed in							3						
	or the nospital or Attending Physician: The law requires that the death certificate be exert, within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-tr.	Medical	(Check 2 <u>Medical Examine</u>	ian: To the best of my knr: On the basis of examina Practitioner: To the best	ation and/or investi	gation, in my opinior	n, death occurre	ed at the time, date an	d place, and due to	the cause(s) and manner stated.				
	vithin To the comp		29b. Signature and title of certifier			29c. License			9d. Date signed (M					
)	b- m	シ	D5653	31		Nov. 4,	2011				
	10		30. Name and address of person who con Harry Li, 8600				lumbia	, MD 21045	5					
	Stat	e	31. Date flied (Worth, Day Year)	_										
	Registra	ır	NUV U 7 2011 /2	32. Registrare Sig	Marke									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 35430 State of Maryland / Department of Health and Mental Hygien [] Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** October 30. ам 5:05 Ε. Joseph Kohlman. Sr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death **Examiner** Howard Columbia Somerford Assisted Living | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 921 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**⅓**M 2□ F Months 89 213-12-3362 Director Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Examiner must be notified at 1 ves 2 No Director N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 ітетв 23а 21229 USA 1249 Pine Heights Ave. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Gyes 2 □ No If Yes, Give Year or Dates: WW II 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. permit. Pages 1 and 2 should be filed within 72 hours after C Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter Important: If item 27 is marked other than "natural", or iter Important or other traumatic event, the Medical Exaction Once. 1 Never Married 2 Married 1 ☐ Yes 2 🖫 No Specify: Specify: White Completed by WW II 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Coast Guard 12 Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Η. Trice Grace 2 F. Kohlman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2008 Kernan Dr., Baltimore, MD 21207 <u>Joseph E. Kohlman, Jr. (Son)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Loudon Park Cemetery 11/4/11 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensea 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 10 Years Immediate Cause (Final Arteriosclerotic Cardiovascular Disease Physician resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) burialattending physician Physician/Medical as the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year jo in the past 12 months? 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Congestive Heart Failure Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Arterial Fibrillation has autopsy performed? Yes 2 No certificate 1 Yes 2 No 1 ☐ Yes Parotitis Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify Living Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မှ 1 ☐ Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Natural 5 Pending To the root.
within 24 hours after deave.
To the Funeral Director: Air 1 ☐ Yes 2 ☐ No M investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 56531 November 3, 2011

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature parked

ORIGINAL

Dr. Harry Li, 8600 Snowden River Parkway, Columbia, MD 21045

11-07924 Steve Kenny Please Type or Print in Black Indelible Ink., Epsure All Copies Are Legible 11 JH amend State of Maryland / Department of Health and Mental Hygiene

35431

	1- For State Certificate of Death									Reg. No.				
Physici	an/	1. Decedent's Name (First, Middle,Last) 2. Date of Death :											3. Time of Death	
edical Exam		Steve Kenny	y						(Month October	21, 20	Year		1358 hrs
		4a. Facility Name (if not institution		er)	4	b. City, To	wn, or Lo	ocation of	Death		4	c. County of	Death	
		106 Bow Street				Elkton						Cecil		
Funeral		5. Social Security Number UTIK	6. Sex 7. A	Age (In yrs. Ia:	st birthday)	If Under	1 Year	If Under :	24Hrs.	8. Date of	Birth(MM	(MM/DD/YYYY) 9. Birthplace (State or		
Director	h		1XM 2 F	53	R Yrs.	Months	Days	Hours	Min.	A 0	2 1	0.50	Foreign Cour	unk/ httyHolland
		Usual Residence of Decedent	12.11	٦.) 119.	1	\Box		<u> </u>	Apr 2	۱ , ۷	1930		HOTTAHA
Aus		10a. State 10b. County	1.	10c. City, 7	Town or Location	on	-					-		IOd. Inside City Limits
B		100	unk									unk		1 Yes 2 No
Maryland 28a-f show d at once.	ģ	MD				406 75 6	N. 1.				40- 03	5 C) A (b	10	
Mary 128s	Director	10e. Street and Number			unk	10f. Zip 0	ode		u	nk	10g. Cit	tizen of Wha		yr
death with the Maryland or items 23a or 28a-f sho must be notified at once.												Ü	ISA	
witi	Funeral		12. Was Decede			s Decedent es, specify				ify Yes or I	No-	14. Race - White,		an Indian, Black,
or ite	Ľ	1 Never Married 2 M	arried Armed Force	s? 2 No un	nk "'	ss, specily	Cuban, n	VIOXICAII, F	dello Mi	Jan, 8(C.)		vville,	eic.	
	by F	3 Widowed 4 Div	orced If Yes, Give Yeer		1	Yes 2	No :	specify:				Specify:	wh:	ite
2 hours afte "natural", Examiner		15. Decedent's Education (Spe		ompleted)	16a. Decedent						16b.	Kind of Bus	iness/In	dustry unk
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 o	r 5+)		st of worki					1	_		
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215 tal H H Ked	Be (Hugh Kenny						Ju1	ia	Mcdor	nald			
21215-0036 hould be filed within 7 nd Mental Hygiene. is marked other than tite event, the Medica	0	19a. Informant's Name/Relations Richard Kenny	ship (Type, Print)	- 5	19b. Mailing	Address .	(Street	and Numbe	er or Bur	al/Ropte N	umber: C	jityy qır Totyrig	State,	Zip (7675
MD 12 sho th and th and umati		Richard Kenny	y/brotner		1-206 1	W. Ba	1tim	ore	Stre	et Ba	1tim	ore,	MD	21201
2 2 2 2 2		20a. Method of Disposition		20b. P	lace of Disposit	tion (Name	of ceme	itery,	D	ate	20c.	Location - 0	City or T	own, State
Ore ges 1 of H		1 Burial 2 X Cremation	3 Removal from S	State cr	ematory or oth	er place)								
Page ment		4 Donation 5 Other S		At1	antic (Crema	tory		1-8-2	2011	G1	en Bu	rnie	, Md
Baltimore, permit. Pages I ar Department of He Important: If ite injury or other tr		21. Signalure of Juneral Sentice RONALC	Licensee Din	ector	22:\N	ame and A	Annt	f Facility B	urge	e-Hei	nss	Seitz	F.H	Street
E E C Z CL	2. 2	John Mi	m -] - B	altım	юrе,	<u> MD</u> -	212	∪±36 :	<u> 11 Fa</u>	lls Rd.	Bal	timore.MD 21
Physician		23a. Part Enter the disease, or failure. List only one cause		ed the death. I	Do not enter th	e mode of	dying, su	uch es card	diac or re	spiratory a	arrest, sh	ock, or hear	†	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease	N.A. JAin La Jain de	s									i	Death
Examiner		or condition resulting in death)	Due to (or as a con	sequence of)	:									
		Sequentially list conditions,	b											
	Je	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of)	:									
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3760, ificate be g physicia s the buria	121	IF FEMALE: 23b, Was decedent pregnant in the	23c. If yes, outcome	ome of pregna	ancy 2 Feta						23	d. Date of d		v Year
68 certii nding	ä	past 12 months?	I LIVE DILLI	at time of dea	th]Ectobic b	negnancy	,		Month	Da	y Year
Box 687 te death certific the attending pred for use as the	/sic	1 Yes 2 No 9 Uni	known 9 Unknown		5 Oth	er (Specif	y)				Ť			
D. E t the d by the	Physiciar	Part II. Other significant condit		ath but not res	sulting in the ur	nderlying c	ause give	en in Part	I.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
ires that the signed by	by				Ü	, ,				1 TY	es 2	No 3	Proba	bly 4 Unknown
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tal Rection: The certificate ector, page		25. Was case referred to medica				26	Place of	f Death (C.	heck only					
Vita ysicia his cer direct	Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat	ient 2 🗸 E	ER/Outpatient					lome 5	Reside	ence 6	Other:	
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Division of Vital Records, talor Attending Physician: The law requir is after death. al Director: After this certificate has been seled in by the funeral director, page 2 should!	cation:		stigation	Injuny As b	ma farm -+ 1					4 1 e	/C+	and Novet	or D	I Doudo Number Of
lor 2 after Dire	 		d not be		me, farm, street	i, ractory, c	orrice buil	aing, etc.				and Number 3, Elkton ,		I Route Number, City
Spital hours a neral 1	Certific	4 Homicide	(Specify) M	ajor Road	/ Highway				∥Rt.	2/9 / Rt.	I-95 NE	s, Elkton ,	MD	
e Hos 124 h e Fur etely	<u>8</u>		hysician: To the best of											
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use as	edical	one) 2 Medicai Exa	miner:On the basis of ex and manner stated	amınation and	d/or investigation	on, in my o	pinion, d	eath occu	irred at th	e time, da	te and pla	ace, and du	e to the	cause(s)
F 2 F 3	ž	29b Signature and title of certifie				29c. l	License r	number			29d.	Date signed	d (Mont	n, Day, Year)
		Dre li	-				O.C.M.	Ε.			Oct	tober 22,	2011	
-		30. Name and address of person	who completed cause of	death (Item 2	23a)									
		Donna M. Vincenti, Mi			,	W. Baltii	more S	treet. B	Baltimoi	re, MD 2	21223			
S Reais		31. Date (1000) 779, 201	1 Denewa	ar sarginatur	Barker									

OCME

1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 0:27A Medical County of Death Facility Name (if not institution, give street Examiner City, Town, or Location touse DICE arro Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Year) Country **Director** 1 □ M 2 🔽 50Yrs. MD -23 show 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c City, Town or Location 10d. Inside City Limits Director be notified 28a-f 1 Yes 2 No 15 TOWN 10e. Street and Numbe ō 10g. Citizen of What Country? 23a Funeral USA items? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban Mexican, Puerto Rican, etc.) Decedent Ever in U.S. i "natural", or iten edical Examiner i 11. Marital Status 14. Race - American Indian, ed Forces? Black, White, etc. by 1 Never Married 2 ☐ Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 2 No 1 Yes Specify 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical once. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry fe. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Surname) ည ene Informant's Name/Relationship (Ty 19b. Mailing Address (Street and Number of Town, State, Zip Code, Husband Method of Disposition 20b. Place of Disposition (Name of Control Communication) cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Vau 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) signed by the attending physician and id be detached for use as the burial-transit Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day 4 Pregnant
9 Unknown Pregnant at time of death 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Wunknown To the Funeral Director After this certificate has been si completely filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed prior to completion of cause of death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 28d. Describe how injury occurred injury 5 Pending 2 Accident
3 Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital within 24 hours a

To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of mento ionanna egistrar's Signatuj State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lillian Linetty November 2011 1:31 PMM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 230 Chimney Oak Drive Harford Joppa 7. Age (In vrs. last birthday) If Under 1 Year I If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗙 F Days Hours 471471922 **Director** Maryland 220-01-6414 89 Usual Residence of Decedent or 28a-f show notified at 10a. State with the Maryland Director 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2X No Joppa 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? be Funeral ms 23a omnust be 230 Chimney Oak Drive 21085 Page 1 and 2 should be filed within 72 hours after death "natural", or iten ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Was Decedent Ever Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 XNo Specify. Completed 3 X Widowed 4 □ Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever P Szymanski Zyglarski Eva 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t; If item 27 is or other tra Christine Frey (Daughter) 230 Chimney Oak Drive Joppa, Maryland 21085 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department o Important: If any injury or 1X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery Dundalk, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es Essex, Maryland 21221 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury Dite to (or as a consequence of) burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): ending physician a r use as the burial-Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERY Completed 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law page 2 autopsy performed? Yes 2 XNo within 24 hours after death.

To the Funeral Director. After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Other: ᅌ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work?
1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of

State Registrar SAVITHA

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back

MACE AVE

BALTIMORE

30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

SHEVANANDA

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 2011 01:17 AM Gregory Lloyd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death ciry Sinai Hospital of Baltimore Baltimore N/ASocial Security Number 6. Sex 1 M 2 D F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of bild, (Month, Day, Year)
Tune 30,1958 Days 220-74-6410 Mary Land **Director** June Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Xyes 2 No N/A Baltimore Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5456 Jonquil Avenue USA 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 X Never Married 2 ☐ Married Black, White, etc. Completed by 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 4 years Security Guard Fox 45 News Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ada Knight Johnny Lloyd Page 1 and 2 should Iment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Derartment of Health an Important: If item 27 is any injury or other trau once. 5456 Jonquil Avenue Baltimore, MD 21215 <u> Ada Lloyd/ Mother</u> 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 11/05/2011 Gwynn Oak, MD 22. Name and Address of Facility Chauman-Harris Funeral Home 21, Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD 21215 eda. Pari 7. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Retween Onset and Death

DAYS Immediate Cause (Final disease or condition Ph sician/ SEPSIS Medical resulting in death) Due to (or as a consequence of) Examiner Pneumonia Day 5 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Diabetes mellitus 1 Yes 2 No 3 Probably 4 Unknown Hypertension . Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☑ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) RIMe RES-000 October, 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rutika Menta 31. Date filed (Month, Day, Year) 2. Registrar's Signature racke NOV 07 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 4:50pm M Rita Louise Lavache October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Timonium <u>Stella Maris</u> 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Ye Months Days 1 □ M 2 🗶 F Hours Min. Yrs. **Director** 95 012-09-6710 Sept. Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director 1 ☐ Yes 2🏋 No Owings Mills Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2049 Hunting Ridge Drive 21117 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles Morrill Elizabeth Magee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Windswept Court, Owings Mills, MD 21117 Elizabeth Jackson Daughter 9805 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings Mills, MD 11/7/11 Garrison Forest Vet 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 10 nen Eline Funeral Home Reisterstown, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ rage Medical resulting in death) Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and a be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death Unknown Unkr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed should been s 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsv page 2 1 Yes 2 No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: Other: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 1 X Natural 5 Pending Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

LAVACHE

OCTOBER

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifie

JUNECIA WHITE, CRNP

NOV O

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

2300 DULANEY VALLEY ROAD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Umedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

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TIMONIUM

21093

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3, Time of Death Physician/ Month 44 PM onica 729 November 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospita vrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 55 2 921545 **Director** 1 🗆 M 2 🗶 F 1958 Usual Residence of Decedent 3 anada show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1

Yes 2 □ No PA Ork 10e. Street and Number 10g. Citizen of What Country? Funeral 7406 USA and 2 should be filed within 72 hours after death Health and Mental Hygiene. tem 27 is marked other than "natural", or items Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10 Be 17. Father's Name (First, Middle, Last) 2 reorge S. Mark 19a. Informant's ame/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) illiam 20a. Method of Disposition 20b. Place of Disposition (Name of 1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State 4 🔭 Donation 5 ☐ Other (Specify) cemetery, crematory Allentown 21. Signature July al Service Line 22. Name and Address PA 18434 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of): Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy į in the past 12 months?
1 ☐ Yes 2 ☑ No Month Year 4 Pregnant at time of death 9 Unknown Day been signed by the should be detached 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N certificate 2 No 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Matural

P.O. Box 68760 Division of Vital Records,

Baltimore, Maryland 21215-0036

within 24 hours after death. To the Funeral Director; A my

EUNPI 31. Date filed (Month, Day, Year) State NOV 0 7 Registrar

Accident

Suicide

4 Homicide

only one)

29b. Signature and title of certifier

29a. Certifier

5 Pending

Investigation

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be

600 N. Wolfe 32. Registrar's

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Medical

work

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Tes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 🗌 No

St Baltimore Maryland 21287

28f. Location (Street and Number or Rural Route Number, City or Town, State)

November 2

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink 4 Firsure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 35437 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joyce Marie McGarry Month 2011 7:35p November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 5204 Gate House Court Sykesville Carroll 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) or 5 1942 1 M 2 J-F Months Days Hours Director 69 MD Isual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits Director MD Carroll Sykesville 1 🗆 Yes 2 ី No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5204 Gate House Court 21784 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married "natural", or If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify: Specify: white 3 XWidowed 4 ☐ Divorced Completed permit. Page 1 and 2 should be filed within 72 hours popartment of health and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Adm. claims examiner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Robert Carter Bessie Savin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Ogle (daughter) 5204 Gate House Ct., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 11-8-11 Sykesville, MD Lake View Memorial 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Haight Funeral Home & Chapel Pargeofaight of evolut P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a con Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a con Exami -transit law requires that the death certificate be executed resulting in death) Last Due to (or as a cons the burialphysician Physician/Medical attending pl 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to a eath but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page performed?
Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No examiner? Hospital: Other: 1 Tes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural the Hospital or Attending 5 Pending work? 1 Yes 2 No after death. Director: Aft Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours a To the Funeral D Medical 29a. Certifier 1 🔭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 027211 who completed cause of death (Item 23a) (Type, Print) engeton The 5/ Musby MD 21784 31. Date filed (Month, Day, Year) State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Oct 2011 9:05 a^M <u>Destiny Moore</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2639 Boone Street Baltimore N/A 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Year If Under 24 Hrs. Hours **Director** 220-53-6688 1 □ M 2 ★ F Feb. 12, 1999 Maryland Usual Residence of Decedent 12 28a-f shov 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No Maryland N/A Baltimore 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 2639 Boone Street 21218 USA items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 X Never Married 2 Married o, þ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify "natural" Completed 3 Widowed 4 Divorced Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) <u>6th grade</u> Student N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Frederick William Moore Terrell Consuelo LeGrand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) : If item 27 is or other tra 2639 Boone Street Baltimore, MD 21218 Terrell C. LeGrand/ Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ᇴ 1 🕷 Burial 2 🗆 Cremation 3 🗆 Removal from State ö Department of Important: If any injury or once. Trinity Cemetery 11/3/2011 Dundalk, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home lest aw 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CONGESTIVE HEART FAILURE disease or condition YEARS Medical resulting in death) Due to (or as a consequence of) Examiner TETRALOGY OF FALLOT WITH PULMONARY ATRESIA SINCE BIRTH Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-transi attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day signed by the at t be detached for Unknown 9 Unknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIGEORGE SYNDROME 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 X No Other: 은 this (1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending iniury death. 1 Yes 2 No Accident Investigation filled in by the Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

3

JOHNS HOPKINS HOSPITHL

D0031002

OCTOBER 31, 2011

200 NORTH WOLFESTREET

ullon MD

32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NANCY HUTTON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35439 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Patricia Ann McGrane 8:30 P. M November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Towson Baltimore Gilchrist Hospice If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Year) 219 26 2188 Director 1 🗆 M 2 🗶 F Maryland 74 10/10/1937 Usual Residence of Decedent ıms 23a or 28a-f show r must be notified at 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Tes 2 X No Anne Arundel Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 U.S. 602 Hammonds Lane Apt. 400 er than "natural", or items the Medical Examiner mu Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items ury or other traumatic event, the Medical Examiner mury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: Specify: 3 X Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) U.S.F. & G. 12th Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ James Redmond Marie Howard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Hicks / Sister 17534 Lincolnshire Road Hagerstown, Maryland 21740 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If i any injury or conce. cemetery, crematory or other place, 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State 11/09/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 21. Signature of Funeral Service Licensee manuerum Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph. sician/ disease or condition resulting in death) Pancos months Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death been signed by the should be detached Unknown Part II. **Other significant conditions** co*n*tributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performed? Yes 2 No Yes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 2 No MOSPILE 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Charles Other (Specify Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending Accident 1 🗌 Yes 2 🗌 No the Investigation 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direction determined Hospital Entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UHMIRS 6701 N Charles ST MO 31. Date filed (Month, Day, Year) 32. Registrar's signature State Registrar NOV 07

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 35440 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Richard L. Millionie 7:20 a M 1, November 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5815 Deer Park Road Baltimore

9. Birthplace (State or Foreign Country) Reisterstown
If Under 1 Year | If Under 24 Hrs. | 8, D 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days Hours Min 1 X M 2 □ F 212-48-7083 64 Oct 29, Maryland Usual Residence of Decedent 10a, State 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5815 Deer Park Road Funeral 21136 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Tx Married 1 ☐Yes 2 ☑ No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 Systems Manager T Rowe Price

18. Mother's Name (First, Middle, Maiden Surname)

Wells

Reisterstown, Maryland 21136

20c. Location - City or Town, State

29d. Date signed (Month, Day, Year) November 1, 2011

Lynette M.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Funeral Director 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a fredical Experimenmust be notified at Richard Milliamie II/1/2011 Baltimore, Maryland 21215-0036 Department of Health ar Important: If item 27 is any injury or other trauonce.

Be

17. Father's Name (First, Middle, Last)

Nancy Millionie

20a. Method of Disposition

(Check only one)

ture and title of certifier

James

19a. Informant's Name/Relationship (Type, Print)

Millionie

and manner stated.

completed cause of death Item 23a) (Type, Print)

Physician /Medical Examiner

> Examiner physician and the burial-transit Physician/Medical attending p Completed page 2 s has certificate

death certificate be Ö σ, Division of Vital or Attending Physician: After thi funeral of within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery: 11/4/11 Pikesville, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 11824 Reisterstown Road aken se Reisterstown, MD 21136 Eline Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 4 tomosdero disease or condition resulting in death) Due to (or as a consequence of) 5 quertially liet or differentially liet any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year 5 ☐ Other (specify) ☐Yes 2 ☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 □ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

5815 Deer Park Road

20b. Place of Disposition (Name of cemetery, crematory or other place)

State Registrar

6 Trumble Hill CT Lutherville, Md

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		For State Registrar	State Of Ivial	•	rtificate of De			20		35441		
Physicia	n/	1. Decedent's Name (First, Middle,	Last)				Date of Death Month	Dav	Year	3. Time of Death		
Medic	al			nn	1		Nov. 1	, 20	11	3:30 a ^M		
Examin	er	4a. Facility Name (if not institution, Lorien Nurs			4b. City, Town, or Lo			4c. County	of Death arrol	1		
Funeral		5. Social Security Number		n yrs. last birthday)	If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth			ace (State or Foreign		
Director		215-20-8507	1 🛣 M 2 □ F	85 Yrs.	Months Days	Hours IVIII.	(Month, Day, Y			yland		
and show at	or	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town or Lo	ocation		mar. 19	1920		d. Inside City Limits		
Maryla 28a-f stified	rect	MD Carroll Westminster								1 ☐ Yes 2 🔀 No		
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of								y?		
ath wif	uner	406 Oakhill C	Court Apt A1	rin II S 12	211 Was Decedent of Hisp		acify Ves or No-	U.S	A. e - America	Indian		
er dea or ite miner	by Fi	Never Married 2 Married	Armed Forces? ied 1 x Yes 2 No		If Yes, specify Cuban,	Mexican, Puerto	Rican, etc.)		ck, White, et			
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2 sho Ith and 27 is I		19a. Informant's Name/Relationsh Kathleen Klinge		- 1	ng Address (Street and Brown Roa				State, Zip Co 2104	_		
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Li			2. Name and Address		.824 Reis					
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Atten er deal ector: by the	ırtifi	2 Accident Investig. 3 Suicide 6 Could n 4 Homicide determin	ot be 28e. Place of Injury				28f. Location (Stre		er or Rural R	oute Number,		
ital or urs afte ral Dir lled in			building, etc. (S				City or Town,					
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of my kaminer: On the basis of exan Nurse Practitioner: To the bo	nination and/or inves	stigation, in my opinion,	death occurred at	the time, date and	place, and due	e to the caus	e(s) and manner stated.		
V Vit		29b. Signature and title of certifier	Middleton	- pur	29c. License n	umber 4 4 2	290	d. Date signed	d (Month, Da	y, Year)		
1/1,0			the completed cause of deat	h (Item 23a) (Type,	Print) Pd U	Cestmin	ister MI) 2/	157			
Stat Registra	-	31. Date filed (Month, Day, Year) NOV 0 7 2(2. Registrar's	Signature	Kel		, , , , , , , , , , , , , , , , , , , ,					
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DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marx Kichard otober 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 219-90-9757 **Director** 45 Dec 10, 1965 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 1 ☐ Yes 2√ No Director Baltimore Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 21222 USA 19 Wells Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2] If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: white ð 3 Widowed 4 Divorced leted 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4 or 5+) transportation 0 cab driver 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Wheeley Richard Joseph Marx Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4208 Silver Spring Road Perry hall, MD 21128 19a. Informant's Name/Relationship (Type. Print) Lee Marx/brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Durial 2 Cremation 3 Removal from State 4 □ Donation 5 📉 Other (Specify) in state 21. Signature of Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Rorald S kide, Direct and 1. Enter the disc se, in complications that caused the rock, or heart failure. List only one cause on each line. Director Baltimore, MD 21201 lions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 30 mins **Physician** Cardiac /Medical Due to (or as a consequence of): Examiner Myoccardial

Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Medical IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 5 ☐ Residence 6 ☐ Other (Specify) After this Manner of Death Date of Injury 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation (Month, Day Year) Injury death. 1 ☐ Yes 2 ☐ No Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State)

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, hours after death

completely filled in by within 24 hours a

> State Registrar

32 Registrar's Signature face

and manner stated

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

m

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(check only one)

29b. Signature and title of certifie

Date filed (Month, Day, Year)

1 (Leftifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per DVR 6922 12/9/11 dk

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 35444 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 26 2011 Kathleen Milligan 11:35A [™] October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Genesis Health Care-The Pines Talbot Easton Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Maryland 118/55 1 □ M 2 😾 F Months Davs Hours Director 219-64-9926 Usual Residence of Decedent ural", or items 23a or 28a-f show I Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗓 No MD Dorchester Hurlock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 303 Wright Avenue 21643 USA "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or þ 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: white 3 Widowed 4 X Divorced Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) self employed restaurant Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ည William Lloyd Sinclaire Margaret Ann Bayne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Sinclaire/brother 404 Acamdemy Street Hurlock, MD 21643 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Signaturs of Euneral Service ्रि श्वार and Addia र र्जानिष्णां Board 655 W. Baltimore Street 21201 Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest , or heart failure. List only one cause on sach line. Interval Between Immediate Seuse (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Certificate: To Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performe 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After I completed filled in by the funera 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Praction of the basis of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10.26-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

Milligan

Kathleen

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ David Rogers 2011 5:00 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Blakehurst Towson Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) 8. Date of Birth **Funeral** 1 X M 2 🗆 F (Month, Day, Year Country) Hawai Days Hours Min. 97 Director 216-12-2558 Jan Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Lutherville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 314 Brightwood Club Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 K Married within 72 hours after 1 ☐ Yes 2 X No Specify. "natural", White Specify: Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Law Attornev 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Christine Rogers Leartus Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 314 Brightwood Club Dr. Lutherville, MD. 21093 Eleanor Owen/ Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pikesville, MD. Druid Ridge Cemetery 11-8-11 ^{22. Name and Address of Facility}
Ruck Towson Funeral Home,
1050 York Rd. Towson, MD. 21. Signature of Fur eral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) nur Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 L retail 33.
Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Certificate: To Be Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 🔁 Natural 5 Pending work' 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SITARON OSS W. JOPPA RUAD TOWN ON IN 1) RUAD TOWSON, IM D

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)
NOV 0 7 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. WS AMEND TTEM#5,10a-c, e, f, perfff#26perfffyS, 6922,12/172011, WS State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 3, 2011 ar 3:26 P M Paul Frederick Obrecht Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lutherville 8208 White Manor Drive 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 - F Hours 82 Months (Month, Day, Year) 5/29/1929 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. Count 10d. Inside City Limits 10c. City, Town or Location Director Maryland Florida Lutherville Indian Creek Vlg. -Baltimore 1 🗆 Yes 2 🕇 No Miami-dade 10e. Treet and Number Creek Island Dr. 10f. Zip 33154-2903 10g, Citizen of What Country? Funeral U.S.A. 8208 White Manor Drive 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces 1 Never Married 2 X Married ☐ Yes 2 X No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 🗌 Widowed 4 🔲 Divorced If Yes, Give Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Real Estate Developer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Fanny Oates George Frederick Obrecht 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8208 White Manor Drive Lutherville, Maryland 21093 Joy Obrecht / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Thomas Ch. Cem. 1 X Burial 2 Cremation 3 Removal from State 11/7/2011 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death An Acute strake Ph. sician Lications ann weeks disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence cry The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events sician and burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 phys the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ brillation 1 Pres 2 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy page death? After this certificate I funeral director, page 1 Tyes 1 Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical B 26. Place of Death (Check only one) Summer 1 Yes 2 No Hospital Other: 4 Nursing Home ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29d. Date signed (Month, Day, Year)
November 3, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W-A-Rivey GBMC/670/ N-N. Charles St. Balto. Md 21204 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ .Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howo If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth Funeral (Month, Day, Country) Maryland 1 🗆 M 2 🔀 F Min. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County Director 1 Yes 2 X No 10g. Citizen of What Country? Funeral U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 2 No Maryland 21215-0036 Yes 1 ☐ Yes 2 Z No If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) $\begin{array}{c} \text{Elementary/Seconday (0-12)} \\ 12\text{th} \end{array}$ College (1-4 or 5+) Inspector Westinghouse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Hubbard Elizabeth Tribull 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Alvis / Daughter Westminster, Maryland 21157 115 Skyline Court Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 11/07/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir signed by the attending physician and be detached for use as the burial-transit Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Matural 5 Pending Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide completed filled in by the Director deg 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, fter determined City or Town, State) Medical 1 Certifying Physician to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examine. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) November 2, 2011 ted cluse of death (Item 23a) (Type, Print) 30. Name and address of person who ca Naqvi 6334 Cedar Lane Columbia, Maryland 21044 Dr. Fatima 32. Registrar's Sign State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end item 23e per doc g921 II-18-II vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2° 2011 ear Bernice RITWO November 11:20 A M Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2901 S. Leisure World Blvd., #237 Montgomery Silver Spring 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign New Introduction) Funeral 1 🗆 M 2 💢 F Aug^{onth},25^y, ^{Yea}l 931 130-22-7619 80 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f 1 Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be by Funeral 2901 S. Leisure World Blvd., #237 20906 United States ral", or items? 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify. Specify: White Completed 3 Divorced 4 Divorced injury or other traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rose Kalischman Samuel Levine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 item 27 Gerald Ritwo, Husband 2901 S. Leisure World Blvd., #237, Silver Spring, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Judean Memorial Gardens 11/4/11 Olnev, MD . Signature of Furjecal Service Licensee Toreninskysskiebrew Funeral Home 254 Carroll St., NW, Washington, DC 20012 Part I Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): ig physician and as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 1 Yes 2 D Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Xes 2 □ No 3 □ Probably 4 X Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has performed? Yes 2 X No certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 🔲 Nursing Home 5 🔀 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 🖾 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending injury 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 2 Accident Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year, November 3, 2011 53177 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 9707 Medical Center Drive, Ste. 300, Rockville, MD 20850 John M. Wallmark, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 0 7 2011 Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

Division of Vital

11-07930 David Rico-Noyola

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 35449

		1- For State Registrar		Certific	ate of	Death			Re	eg. No.		
	Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year							ear	3. Time of Death			
Cadlean Examiner David Rico-Noyola October 21, 2							1, 2011		1458 hrs			
				4	b. City, Town, o Columbia	or Location of	f Death		4c. County of Death Howard			
F									Date of Bird			hnlace (State or
Funeral Director		Months Days Hours Min.								Foreig	n untry)	
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Towr	or Locatio	on						10d. Inside City Limits
		MD Howard Columbia								1 Yes 2 No		
laryland Sa-f sho	cto	10e. Street and Number	- u	0.0	JI GIIID	10f. Zip Code			T 10	Og. Citizen of V	Vhat Cour	
th the Ma 23a or 28 notified	Il Director	8450 Dorsey Ru	1	_			20794					
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21215-0036 and be filed within 7 Mental Hygiene. marked other than	æ											
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examines.	၉	19a. Informant's Name/Relations	hip (Type, Print)	1.0		Address (Stre				· -		Zip Code)
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 Burial 2 Cremation	3 Removal from Sta		tory or other		errietery,	J	ale	200. Localion	r - Oily oi	rown, State
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Baltimo permit. Page. Department o Important: injury or oth		21. Signature of Funeral 9 ryice Rottal d	6 Made, Dir	ector	St.	me and Addre ate Ana	ss of Facility Itomy I	Board	655 W	. Balt	imore	Street
Physician	-	23a. Rart I. Enter the disease, or	complications that caused	the death. Do n	Ba	1 timore	MD 1	21201				Approximate Interval
VMedical	8.5	failure. List only one cause	on each line.			,	5,			,		Between Onset and Death
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P.O. Box 687 s that the death certific gned by the attending is e detached for use as the	Physiciar	1 Yes 2 No 9 Unk	known 9 Unknown		5 Oth	er (Specify)				1		
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Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the Ameral director, page 2 should be detached for use as	Medical		nysician: To the best of my miner:On the basis of exan and manner stated.									
F. W. P.	₩.	29b. Signature and title of certifie				29c. Licen	ise number			29d. Date sig	ned (Mon	oth, Day, Year)
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OCME	Ì	30. Name and address of person Mary G. Ripple MD.	who completed cause of de		r 900 \	V. Baltimor	e Street. I	Baltimo	re, MD 21:	223		
S	ate	31. Date filed (Month, Day Year)	32. Registrar	's Signature								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day October 11:58 P M Barbara M. Ree 2011 27, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harrford Harford Memorial Hospital Havre de Grace If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 07 Day. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, 1□M 2**X**F 1934 77 Unadilla. NY Yrs 082-28-2654 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Maryland Harford Jarrettsville 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 21084 U.S.A. 2750 Azure Ct. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Secretary - Perry Hall Christian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Claude Mason Anona Griswold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. George E. Ree (Spouse) 2750 Azure Ct. Jarrettsville, Maryland 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State November 05, 2011 1 ☐ Burial 2 ☐ Cremation 3 🕅 Removal from State Evergreen Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Unadilla, NY 21. Signature of Funeral Service Licensee Jeffrey R. Testerman 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services - Bel Air (MO1543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonare Que to (or as a consequence of): Kidne if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): etast to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 ŪNo 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2₽No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Physician /Medical Examiner Q Box 68760, requires that the death certificate be 35 Records, Vital o Division Ò

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Director: After this certifice 24 hours a Hospital the .0

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29b. Signature and title of certifier

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31. Date filed (Month, Day,

ed other than "natural", or items 23a or 28a-f show event, the Medical Evantings must be notified at

Baltimore, Maryland 21215-0036

Health and Mental Hygiene.

Pages 1 and 2 should be

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permit. Pages i....
Department of Health and Important: If item 27 is

page 2 completely filled in by the

State

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number D 0065827

Chesapeake Dr Bel ar MD 2014

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Cecelia Month Jane Sniadach 5:03 рм November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7300 Ridge Road Marriottsville Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, V 1 □ M 2 🖫 F Months Days Hours Year) 162-22-3116 83 Director Sept 1928 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Carroll Marriottsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7300 Ridge Road 21104 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗆 XV o Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours att. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any Injury or other traumatic event. 1 ☐ Yes 2 ☐ No Specify: 3 🗓 Widowed 4 🗆 Divorced Specify: white Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Security Adm. Data Entry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theodore J. Parnell Josephine Walchesky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Roy (daughter) Colodon Farms Dr., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State All County Cremation | 4 Donation 5 Other (Specify) 11-7-11 Sykesville, MD Signature of Funeral Service Lice 22. Name and Address of Facility Haight Funeral Home & Chapel 1/1/1 Box_ 195 Sykesville. MD 21784 . 0 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on alch line. Approximate Interval Between Onset n Death Immediate Cause (Final Physician, a disease or condition resulting in death) Medical Due to (or s a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and thed for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death Year To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural 5 Pending death. 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0624 20

State Registrar 110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar	State of Maryla	and / Depa		Health and	Mental Hy			35452		
Physicia Medic		Decedent's Name (First, Middle, Las.	BARBARA JUNI	ON		2. Date of Dea Month OCT 2						
Examir	er	4a. Facility Name (if not institution, give: WRNMMC	street and number)			or Location of Dea	th		ty of Death MONTGOMI	FRY		
Funeral Director		5. Social Security Number 6. Se 233–50–3591	x 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Day	r If Under 24 Hrs	8. Date of Birti (Month, Day			e (State or Foreign		
3	Ļ	Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo	cation		June 1	0,1733	104 /	Inside City Limits		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	VA Prince W		odbridg						1 Yes 2 X No		
	ralD	10e. Street and Number 13013 Smoketown Ro	nad		10f. Zip Code 22192			10g. Citizen of	f What Country?			
	至	11. Marital Status 1 Never Married 2X Married 3 Widowed 4 Divorced	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give			Hispanic Origin? (S ban, Mexican, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Ra Bla	14. Race - American Indian, Black, White, etc. Specify: White			
hin 72 hour ne. than "natur e Medical	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Seconday (0-12)	Year or Dates. ucation de completed) College (1-4 or 5+)	(Give I life. Do	O NOT use retire	e during most of wo	orking		Business Industr	у		
lled wit I Hygier other i	Be	17. Father's Name (First, Middle, Last)	12 Home				me (First, Middle, I	Own Home				
uld be f I Menta narked natic ev	70	Joseph David Grim					Shaw Me		,			
d 2 shoralth and 27 is n		19a. Informant's Name/Relationship (Type) Donald Douglas S1a		1		et and Number or Ru rive, Aus			State, Zip Code,)		
Page 1 and nent of Hea int: If item iry or othe		20a. Method of Disposition 1 X Burial 2 Cremation 3 4 Donation 5 Other (Specify	20b. Removal from State	Place of Dispo cemetery, cren		lace)	Date	20c. Location	- City or Town,	State		
permit. I Departm Importa any inju		21. Signature of Funeral Service License		22	, Name and Add	ress of Facility Mo	untcast1	e Turcl	h Funera	1 Home		
Physician / Medical Examiner sthe prival-transit	Il Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death PANCREATIC CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause First Indaying Cause (Disease or inijury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):										
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requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions con		itribute to the car	use of death?							
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tending Pr death. tor: After th the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 1 August 2 Accident Investigation 1 August 2 Accident Natural Superior Produption Investigation					be how injury occurred				
pital or At ours after o eral Direct filled in by		4 Homicide determined determined 286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Rout City or Town, State)								· 		
the Hos iin 24 h the Fun ipleted	Medical	only one) 3 \(\subseteq\) Certifying Nurse	On the basis of examinating Practioner: To the best of r	on and/or investi ny knowledge, d	gation, in my opir eath occurred at	nion, death occurred the time, date and pl	at the time, date an ace, and due to the	id place, and di cause(s) and m	ner as stated. ue to the cause(s) nanner as stated.	and manner stated		
P V V V V V		29b. Signature and title a certifier				se number		^	ed (Month, Day,)			
Var		30. Name and address of person who co	mpleted cause of death (Ite			4489 (NE)	WRNMMC	UCT,	27 20r	<u>/</u>		
)V		DOUGLAS F. POWE		USA			BETHESDA	MD 208	389-5600	<u>; </u>		
Stat Registra		31. Date filed (Month, Day, Year) NOV 0 7 2011	32. Registrar's Sign	a de								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Mabel Stanford 2011 Nov 6:45 p^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 217-20-7625 Hours **Director** 91 May 11, 1920 Maryland Usual Residence of Deceden 28a-f show 10a, State 10b. County with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD N/A Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5608 Stonington Avenue 21207 USA Page 1 and 2 should be filed within 72 hours after death v ment of Health and Mental Hygiene. 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuptan, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify "natural", 3 ☑ Widowed 4 ☐ Divorced Specify: Black Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Housekeeper Private Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Cornelius Smith Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Milford Stanford - Son 27 5608 Stonington Avenue Baltimore, Maryland 21207 t: If item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If any injury or Woodlawn Cemetery 11/5/2011 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD. 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or covition resulting in d. ath) Onset and Death Physician/ Medical Due to (or as a onsequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) vasculer de scate burial-transit death certificate be executed and that initiated events resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
 5 Other (specify) for in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🞾nknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law After this certificate has autopsy perform death? Yes 2 No 1 🗌 Yes npletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Tes ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA Other (Specify) 4 Nursing Home 5 Residence Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation Μ 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifier COU 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HARUES MO ST 70

State Registrar 31. Date filed (

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 35454 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ^{Day} 2011 а М Malcolm Sebring Rose 31 7:30 Medical Oct. 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Health Center Be1 Air Harford Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Davs June 21, Hours Year) **Director** 579-26-0722 Maryland 85 1926 Usual Residence of Decedent 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f Baltimore Reisterstown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code must be i 10g. Citizen of What Country? by Funeral 4 Glyntree Garth 21136 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 14. Race - American Indian, Black, White, etc. Armed Forces 1 Never Married 2 Married 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Completed 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Family Motel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samue1 Eugene Rose Ethel Marie Sebring 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dennis Smith Nephew 4 Glyntree Garth Reisterstown, MD 21136 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Olivet Cemetery 11/1/11 Frederick, Maryland 21. Signature of Funeral Gervice Licenses 22. Name and Address of Facility 11824 Reisterstown Road Mep ren ELINE FUNERAL HOME Reisterstown, MD 21136 23a. Part 1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiorespiratory disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe PNEUMONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Vear 9 🗌 Unknown Unknown ias been signed by 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Head and neck cancer 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 No Hospita Other: 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifier asni Khara D63420 October 31, 2011

State Registrar DHMH 17 Rev 7/2009 Dr. Bel Air , MO 21014

Sid 2. Knard, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month AVIS Sanders 3:25 p November 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death seasons 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (In yrs. last birthday) **Funeral** Director 1 🗆 M 2 🗷 F 58 28a-f show 10b. County ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No owie heorge 10f. Zip Code 10g. Citizen of What Country? Funeral 2072 1 USA items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. 0 1 ☐ Yes 2 🗶 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 27 is marked other than "natural", traumatic event, the Medical Exar Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) NaiNeer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden S ပ mes .. Page 1 and 2 should b tment of Health and Me tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 1002 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot Date 1 D Burial 2 X Cremation 3 D Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Cremator 22. Name and Address of Facility Greene Funeral Home INC. 21. Signature of Funeral Service Licensee AIEX. UA 22314 Franklin ST. 23a. Part 1. Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. shock, or heart failure Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ WERINE (ancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or in that initiated events the burial-tran pue Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ģ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death detached g Unknown g Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed Yes 2 certificate filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other Specify nt hapite 2 🗷 No မ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending injury 1 / Natural Accident Investigation M within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifier 2 29d. Date signed (Month, Day, Year) nskajaparnimin 00057465 11/3/11

Registrar DHMH 17 Rev 06-2011

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N S Rajapa K& M D 2835 Sm Mh /N

32. Registrar's Signature

S Rajapa KoliM'D

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Schmidt Danie 8: 16A M Worem ser Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 37 Thomas Rd. Glen Burnie 5. Social Security Number 6. Sex If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1946 Mary Land 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 215-46-9093 **Director** 65 1 【 M 2 □ F Usual Residence of Decedent 28a-f shov 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Glen Burnie MD 1 Yes 2 X No Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 37 Thomas Rd. 21060 death \ Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗙 No Specify. "natural", Specify: 3 Widowed 4 Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Manufacturer 12 Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, မ Ruth Charles Schmidt Sr. Chelplis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If item 27 37 Thomas Rd., Glen Burnie, MD 21060 Florence M. Schmidt (Wife) other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Loudon Park Cemetery 11/9/11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loudon Park Funeral Rome Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death END-Stack LOPD Ph. sician/ disease or condition Medical resulting in death) Due to (or as a cons quence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events physician and the burial-trai Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of Was an has page 2 autopsy performed death? after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No ☐ Accident☐ Suicide Investigation 6 discould not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number Mskajapalmem.1) 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209

Registrar DHMH 17 Rev 06-2011

State

5. Rajapakse, M.D

Date filed (Month, Day, Year,

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2835 Smith AV

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiena Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Vea **Physician** Month 5.35 2011 0 /Medical cility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner AMILTON HATEGORD RD BALTIHOR (-(JENES 15 (540 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. lest birthday) 8. Date of Birth (Month, Oay, Year) **Funeral** Hours Months Days 1 M 2 L 219-16-4909 89 Director Nov 20, Maryland Usuel Residence of Decedent with the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours efter deeth with the Marylar Depertmant of Health end Mentel Hygiene. Important: If item 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event, Ital Medical Examinat must be notified at N☐ Yes 2 No Director MD Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA 2918 glenmore Avenue 21214 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Maritel Status 1 ☐ Yes 2 🕅 No If Yes, Give 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: 2 3 ☐ Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation unk 16b. Kind of Business/Industry unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk Be unk 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 6040 Harford Road Baltimore, MD Hamilton Center 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4□Donation 5 NOther (Specify) in state 21. Signature of Funeral Selvi State and Address of Facility and 655 W. Baltimore Street Di/rector Baltimore, MD 21201 rthe disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical nonessive Examiner Be Completed by Physiclan/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attanding physician end for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. that initiated events resulting in death) Last Due to (or as e consequence of) been signed by the s should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? 20 No 3 ☐ Probably 4 ☐ Unknown 1 | Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? funeral diractor, page 2 1 ☐ Yes 2 ☐ No IL Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) edical Certification: To | Hospital: Other: 1 Yes 2 No 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA this Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident death. I Director: A 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) filled in by 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral C completaly filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. (Check only one) 29d. Date signed (Month, Dey, Yeer) 29b. Signature end title of certifier 29c. License number 1>7078 0 30: Name end eddress of person who completed cause of death (Item 23a) (Type, Print) Baltinure HD 2/20 821 MITSANI MA DIMITRA N. GUTAW 5712 32. Registrer's Signatu 31. Date fil State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 20, 2011 6:44 PM M Richard J. Tarnef Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery 10800 Georgia Avenue Silver Spring 5. Social Security NumbellIIK | 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth g, Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Min (Month, Day, Year) Director 1 X M 2 D F June 1, 1958 53 Maryland Usual Residence of Decedent 10d Inside City Limits 10a. State 10b County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 28a-f 1 🗌 Yes 2 🖵 No Silver Spring Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a o Funeral 10800 Georgia Avenue 20902 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 6 Completed by 1 Never Married 2 Married Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify white "natural" 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) Mental Hygiene. unk unk sales clerk toy store Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental H item 27 is marked of other traumatic evel ပ Page 1 and 2 should be 1 Leon Tarnef 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3073 Oakland Road Louisa, VA Andrew Tarnef/son other 1 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State . = .o 1 Burial 2 Cremation 3 Removal from State Important: If any injury or once, 4 ☐ Donation 5 🛛 Other (Sp. Funeral Service ്ട് പ്രാക്ഷ് Aria ക്രിക്ക് Board 655 W. Baltimore Street Sign tor 21201 Baltimore, MD 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Betw Physician/ disease or condition resulting in death) -ascimona Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the b IF FEMALE: use a yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death 5 Other (specify) Yes signed by the ar g Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen Were autopsy findings available prior to completion of cause of 24a. Was an ate has page 2 s autopsy performed' death? this certificate 1 Yes 2 No 1 Yes 2 X No • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Other: 2 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniury work? 1 Yes 1 X Natural 5 Pending 2 No Accident Investigation

filled in by the within 2 To the I

Medical

6 Could not be

determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Suicide

4 Homicide

29a. Certifier

(Check

only one) 29b. Signature and title of certific

31. Date filed (Month, Day, Year)

NOV 0

Registrar DHMH 17 Rev 06-2011

State

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 mo ome

32. Registrar's Signature

. Location (Street and Number or Rural Route Number,

29d. Date signed (Month, Day, Year)

City or Town, State)

HOWARZ VINCENT 11-07655 PA

nk Unk		State of Maryland / Departr				OFLEG	
IK OHK		1- For State Certific	cate of Death			35459	
Physicia	ın/	Registrar 1. Decedent's Name (First, Middle,Last)		2. Date of Dea		3. Time of Death	
ledical Exami		Howard Vincent	Month October 1	Day Year 2, 2011	1700 hrs		
}		4a. Facility Name (if not institution, give street and number)	of Death	4c. County of Death	1		
		5. Social Security Number unk 6. Sex 7. Age (In yrs. last b	Baltimore irthday) If Under 1 Year If Und	er 24Hrs. 8. Date of Bir	th (MM/DD/YYYY) 9. Bir	tholace (State or	
Funeral Director		11	Months Days Hours	s Min.	Foreig	in unk	
		1 M 2 F 56 Usual Residence of Decedent	Yrs.	Aug 9	, 1955 ^{co}	unity)	
Any.		10a. State 10b. County 10c. City, Tow	n or Location			10d. Inside City Limits	
and show	F	MD	Baltimore			1 Yes 2 No	
Aaryla 28a-f	Director	10e. Street and Number	10f. Zip Code	1	10g. Citizen of What Country?		
a the A		605 Biddle Street	21201		USA		
h with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces? un]	13. Was Decedent of Hispanic Ori		 14. Race - Ameri White, etc. 	can Indian, Black,	
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215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. riced other than "natural", or items 23a or 28a-f sheent, the Medical Examiner must be notified at once		17. Father's Name (First, Middle, Last)	unk ^{18.Mothe}	's Name (First, Middle, I	Maiden Surname)	unk	
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shoul and N	٩	19a. Informant's Name/Relationship (Type, Print)	9b. Mailing Address (Street end Nur 900 W. Baltimore			21223	
and 2 and 2 lealth item 2		20a. Method of Disposition 20b. Place	of Disposition (Name of cemetery,	Date Date	20c. Location - City or		
nt of F		T Durial 2 Cremation 5 Tremoval nom state	atory or other place)				
Baltimore, permit. Pages I an Department of Hea Important: If iten injury or other tri		21. Signature of Funeral Service Licensee	225 Name and Address of Facilit	Board 655 V	V. Baltimor	e Street	
E Per Co		convil //ce	Baltimore, MD	21201			
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List-only one cause on each line.	not enter the mode of dying, such as o	ardiac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and	
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Car	diovascular Disea	se		Death	
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	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
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68 certifi	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 1 Pregnant at time of death		pregnancy	Month D	ay Year	
Box 68760, e death certificate be the attending physic at for use as the burst of for use as the burst of the second seco	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)				
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al R	Bec	25. Was case referred to medical examiner?	26.Place of Death				
bysic al dire	٥	1 ✓ Yes 2 No	Outpatient 3 DOA Other		Residence 6 Other	Scene	
ding I	5	1 X Notucel (Month, Day, Year)	. Time of Injury 28c. Injury at Work		now injury occurred		
SiOl Atten r death ector: by the	cati	2 Accident Investigation	farm, street, factory, office building, et		Street and Number or Ru	ral Route Number City	
Division of Vital Records, P.O. Box 68760, spital or Attending Physician: The law requires that the death certificate be ours after death. seral Director: After this certificate has been signed by the attending physici filled in by the funeral director, page 2 should be detached for use as the buri-	Certification:	Suicide Could not be determined (Specify)	rami, street, factory, once building, et	or Town, S		rai riodio ridinosi, ony	
Hospid 74 hour Funer ely fill		4 Homicide 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, di (Check only)	eath occurred at the time, date and pla	ace, and due to the caus	e(s) and manner as state	ed.	
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FSFS	ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor		
		MI	O.C.M.E.		October 13, 2011	3	
	İ	30. Name and address of person who completed cause of death (Item 23a)	r 900 W. Baltimore Street,	Raltimore MD 241	223		
<u> </u>		Russell Alexander MD. Assistant Medical Examine 31. Date filed (Month, Day, Year) 32. Registrar's Signature	- 300 vv. Dalumore Street,	Baltimore, MD 212			
Sta Regista		NOV 0 7 2011	barks				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Registrar

DHMH 17 Rev 06-2011

State

10770 CHARTER DR 12310 COUMBIA MO 21044

Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DAVID O. NYANTOM MD

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of IVI	aryiand / Depa <i>Cer</i>	artment of F tificate of L		, ,	201	1 25161		
			Decedent's Name (First, Middle, Last)		imouto or i	20411	2. Date of Death	eg. No	3. Time of Death		
Н	Physicia Medic		Gina Carol Woolfs	on			Nov. 6	5, Day 2011 Ye	1:27A M		
	Examir	er	4a. Facility Name (if not institution, give street and number) Gilchrist Hospice Cent	02	_	r Location of Death		4c. County of Death			
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21215-0036	72 hours after death with the Maryland "matural", or items 23a or 28a-f sho ledical Examiner must be notified at	ted	3 Widowed 4 Divorced If Yes, Give 'Year or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify:	White		
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Maryland	should be file h and Mental h 7 is marked or traumatic evel	ř	James Henry Tracey					e Turne			
Ma	2 sho Ith and 27 is r traur	Y/	19a. Informant's Name/Relationship (Type, Print) husb Geoffrey S. Woolfson	and 196. Mailin	_	and Number or Rura Dr. Wes		-			
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Baltimore,	Page tment tant: It		1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Meadow E	Branch (Cem. 11/		Westmin			
Ball	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Fineral Service Licensee Normal D. Fundus	22 25	Name and Addre	ss of Facility Flain St.	etcher Westmir	Funeral	l Home, P.A MD 21157		
	Ph ₋ sician/ Medical Examiner		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a line)	. 1	er the mode of dyin	g, such as cardiac c	or respiratory arres	st,	Approximate Interval Between Onset and Death		
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Rec	The lar ate ha	mo.					autops perform 1 \(\sum \) Yes 2	ned? dear	r to completion of cause of th? I Yes 2 □ No		
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			30. Name and address of person who completed cause of d PARON J CHARLE	S mD	(rint)	N Chan	les S.	1 Too	65 m		
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registra	ar's Signature	W						

DHMH 17 Rev 7/2009

11-08215 George Wells Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

George vveils		1- For State Registrar	Stat	e or maryia	-		nt of Hea e of Dea		d Mental I	hygiene	Reg. No	20		35462
Physicia Medical Exami	an/	Decedent's Nam		ast)						2. Date of Month			7	3. Time of Death 1210 hrs
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Francis		Southern M 5. Social Security I	laryland Hos	pital Sex	7. Age (In yrs.	last hirthd	Clint	on der 1 Yea	ar if Under 24H	re Is Data		Prince Ge	9	S place (State or
Funeral Director						88	Yrs. Mont			in.	19/1		Foreign Cour	Washington
any		Usual Residence of 10a. State	of Decedent 10b. County		10c. Cit	y, Town or	Location						$\overline{}$	10d. Inside City Limits
▶	٦,	DC	None		Wa	ashin	gton							1 X Yes 2 No
he Maryli or 28a-f	Director	10e. Street and Nu 5116 A S	HASSA	.E.			10f. Zi 200	ip Code			10g. C	itizen of Wha A	t Count	ry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show injury or other traumatic event, the Medical Examinet must be notified at once.	uneral	11. Marital Status 1 Never Marr	ied 2 XMarr	ied Armed F		U.S. 1	3. Was Deced	lent of Hi cify Cuba	spanic Origin? (n, Mexican, Puer	Specify Yes of to Rican, etc.	or No-	14. Race - White,		an Indian, 8lack,
after de	by Fu	3 Widowed		1 X Yes ced If Yes, Give Yea or Dates:	2 No		1 Yes	2 <u>₹</u> No	specify:			Specify:	В1а	ıck
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Vital hysician: this certi	o Be	25. Was case reference examiner? 1 ✓ Yes		Hospital: 1	Inpatient 2	✓ ER/Outp	atient 3	26.Plac	Other Nur	sing Home 5	Resid	dence 6	Other:	
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Division To the Hospital or Attenwihin 24 hours after death To the Funeral Director:	edical	29a, Certifier (Check only one) 2	Certifying Phys Medical Exami	sician: To the besider:On the basis	of examination	edge, death and/or inve	occurred at the estigation, in n	ne time, d ny opinio	late and place, a n, death occurre	nd due to the	cause(s) a	and manner a place, and du	is stated e to the	d. cause(s)
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9		30. Name and add Melissa Bra		no completed caus Assistant Me			00 W. Balt	imore S	Street, Baltim	ore, MD 2	1223			
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 35463 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 Month 29 Day 2011 Pear Dolores Yvonne Williams 3:15 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Prince George's Fort Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛣 F o*™31171*937 **Director** 579-52-0001 Washington, DC 74 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any Injury or other traumatic event, the Medical Examiner must be notified at once. or 28a-f show 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1

Yes 2 □ No MD Prince George's Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6801 Bock Road 20744 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Be Completed by Black, White, etc 1 Never Married 2 Married Yes Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: **Black** 3 ☐ Widowed 4 🔀 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Social Worker Government vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John D. Williams Bernice Lomax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Williams/Son MD 20744 Baltimore, Stag Way Ft. Washington, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 4 Donation 5 Other (Specify) Ft. Lincoln Cemetery 11/11/2011 Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home Suitland, Suitland Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one call Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** 0 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2. No 5 Other (specify) Month Day Pregnant at time of death Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 2 👿 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Certificate: To 1 🗌 Yes Other: 1 Nnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes After 28d. Describe how injury occurred 5 Pending injury within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical (🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 0024064 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6196 + 20 SHANTHA K. 31. Date filed (Month, Day, Year) 3. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1 Month 01 Day 201 Yar Louise E. Wills 6:50 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6611 Dalton Dr. N/A Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-32-7468 8. Date of Birth Hours Director 1 M 2 DA 07/27/1935 76 Maryland 28a-f shov 10a. State 10h County 10c. City, Town or Location notified at 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e, Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Medical Examiner must be 23a Funeral 6611 Dalton Dr. 21207 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 5 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: natural", Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry (Specify only highest grade completed) i Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 曹 Nursing Center LPN years other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental H 7 is marked ot မ Arthur Blue El Lucy El 19a. Informant's Name/Relationship (Type, Print) (Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh it of Health a Sheila Wills Johnson 4023 Norfolk Ave., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State injury or Department of Important: If any injury or on-site Crematory 11/03/11 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 30sepHddFs.ofFBFown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Parl 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) 20005 resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy o in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death Day 2 No 9 I Inknown q 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician; The law requires 1 \square Yes 2 \square No 3 \square Probably 4 \square Unknown 120511 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 40 Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, this funeral (27. Manner eath 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural 5 Pending injury the f Accident Investigation M 6 Could not be Suicide filled in by Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 24 hours a Funeral I Medical 👺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou

To the Fune

completely fi 29a. Certifier 2 Gertifying Nurse Practitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check License number 29d. Date signed (Month, Day, Year) 30. Name and address of

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (N

2. Registrar's Signa

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 35465 Certificate of Death Rea No . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Henry Weston Jr. 201 October 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death maryland Greneral Hospital Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) (Month, Day, Year) 214-26-5775 Months Hours 1**√** M 2 □ F 12/25/1930 Maryland 80 10c. City, Town or Location 10d. Inside City Limits 10a. State 1X Yes 2 ☐ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. McMechen St. Apt 521 21217 301 12. Was Decedent Ever in U.S. Armed Forces?

1 5 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 XNever Married 2 Married 1 Yes 2 XNo Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Armco Steel Steel worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. Weston Sr. Margaret Ann Jordan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeffery Newton(nephew) 3136 Woodring Ave., Baltimore, MD 21234 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State 11/09/11 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Owings Mills, M D 21. Signature of Funeral Service Licenses එර්පිළුහිෆ්ල්ස් පිරිත්ත Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD MD 21217 Approximate Interval Between Onset and Death to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 3 Fctopic pregnancy Pregnant at time of death 5 Other (specify) g Unknown 23e. Did tobacco use contribute to the cause of death?

Ph. sician/ Medical **Examiner**

Physician/

Medical

Examiner

Funeral

Director

28a-f show

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Department of Health ar Important: If item 27 is any injury or other trauonce.

Director

Funeral

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filed within 72 hours after death with the Maryland

Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran attending physician the ed by the a been signer should be d page 2 certificate funeral director,

Division of Vital Records, P.O. Box 68760

þ Completed Be မ Certificate:

Division	To the Hospital or Attendi	within 24 hours after death.	To the Funeral Director: A	completely filled in by the fu
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed? 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ₺ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending injury 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/29/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sangue Shrestha, m.D. Go Maryland Greneral Auspital

DHMH 17 Rev 06-201

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Esther Joyce Waters Oct. 31. 2011 4:00 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 2825 Lodge Farm Road Apt. 211 Baltimore Co. Edgemere Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth **Funeral** Months (Month 214-30-3386 **Director** 1 □ M 2 🗓 F Oct 16,1933 78 Pennsvlvania Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Baltimore Edgemere 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? iral", or items 23a or Examiner must be Funeral 21219 2825 Lodge Farm Road Apt. 211 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. "natural" Specify: Completed 3₺ Widowed 4 □ Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4 or 5+) Billing Clerk 12 Years Transportation ed other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ith and Mental H
27 is marked of
traumatic ever မ John A. Ennis Esther M. Dishart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a 6708 Hudson Street Baltimore, Maryland Paula J. Waters (Daughter) other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ō Department
Important: Ii
any injury or Hilltop Service Corp, 11/5/2011 Towson, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lices ²²Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Day Month Year g Unknown signed by significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate has performed

Yes 2 or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 MNo ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO046593 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9110 Philadelphia Road Suite 106 Baltimore, Maryland 21237 Shelia Alongi 32. Registrar's Signature State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:15 PMM 201^T October Medical Raymond Watts 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery 118 Monroe Street Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. Director 274-22-5335 1 X M 2 🗆 F 86 Oct 24, Ohio 28a-f show death with the Maryland ral", or items 23a or 28a-f shorexaminer must be notified at 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 118 Monroe Street #1310 20850 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black. White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", 3X Widowed 4 ☐ Divorced white Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 5+ lega1 lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas Raymond Watts Dorothy Mildred Day 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 1283 Thomson Road Abington, PA 19001 Kathryn Watts/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 X Donation Sther (Specify) State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 irector art 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a cons **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death Other (specify) ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No this certificate has page 2 2 🗆 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🗙 Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 2 Accide 5 Pending ithin 24 hours after death.

the Funeral Director: Af
ompletely filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2.

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complet 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number

State Registrar 30. Name and address of person who

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31. Date filed (Mo

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d cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 2 2011 11:29PM Teara Dorshay Willis Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner n/a 209 South Spring Court Baltimore Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 09/11/1990 Hours Min 213-31-2708 1 🗆 M 2 🔀 F **Director** 21 MD Usual Residence of Decedent , or items 23a or 28a-f show aminer must be notified at 10d. Inside City Limits 10a, State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location Director MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21231 209 South Spring Court n "natural", or item edical Examiner n 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black Completed 3 Widowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) n/a unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o Frank Dorsey Willis Karen Lipscomb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyra Willis - Sister 209 S. Spring Ct. Baltimore, MD 21231 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cemetery 11.9.2011 Baltimore MD ature of Funeral John L. Williams Funeral Directors, P.A. 4517 Park Heights Ave Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused strock, or heart failure. List only one cause on each line. Immediate Cause (Final 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death DissemiNATED Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 000R 24 Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause or injury COMPLIANCE should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Day Month Year Pregnant at time of death Teara P.O. ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, DAYNOPHAGIA 1 ☐ Yes 2 TNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed? Yes 2 No 1 ☐ Yes 2 ☑ No Division of Vital furieral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Separate Residence 6 Other (Specify) 1 Tes 2 🎦 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending efter death. 1 🗌 Yes 2 🔲 No Accident Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours -Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completely (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D002290 toyel, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Michael Hoyer 828 N. Eutaw Street Baltimore, MD 21217 31. Date filed (Month, Day, Year, 32. Registrar's fignature State NOV 0 7 2011 Registrar

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State of Maryland / Department of Health and Mental Hygien [9]

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			1. Decedent's Name (First, Middle	e, Last)							th	Voor	3. Time of Death
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	ieaic amin		4a. Fecility Name (If not institution	n, give street and number	·)		4b. City, Town, or	Location	of Deeth		4c. County of Death		1
			1314 Glenwi	1de Rd			Catonsville				Baltimore		
Fund	eral		5. Social Security Number		7. Age (In yrs. last birthday) If Under 1 Year			If Under		8. Date of Birtl	Year	plece (Stete or Foreign	
Direc			217-34-6917	1□M 2∏F	74	rs.	Months Days	Hours	Min.	8. Date of Birtl (Month, Pay June 9,	1937	Mary	land
pr ,	20	}	Usuel Residence of Decedent		10. Oit. T.								10d. Inside City Limits
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or 2	2	Funeral Director	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Co	untry?
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Hygir Hygir	ť		17. Father's Name (First, Middle,	Last)		ACC	countant	18. Moth	er's Name	e (First, Middle,			
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C, F	9		Donald F. Yakel 20a. Method of Disposition	. (Husband)			Glenwild	e ku		Date		on - City or	
Saltimore, permit. Pages 1 at Department of Hea Important: If Item	0 0		1 🔀 Burial 2 □ Cremation	3 □Removal from State	cemeter	y, crem	natory or other plac						
Figure Pa	r.		`4 □Donation 5 □ Other (S		Loudon	_	rk Cemete						Maryland -
Department of Important: If It	PDCG		21. Signature of Funeral Service	License		22.	. Name and Addres						
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فيو	-		23a. Part T. Enter the disease, or shock, or heart failure. List	r complications that cause t only one cause on each	ed the death. Do r line.	ot ente	er the mode of dyin	g, such as	cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
hysic			Immediate Cause (Final disease or condition	. End	Stage .	SU	pranuc	wor	pa	lsy			Orisot and Obatin
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BOX eath cert	or us		23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom 1 ☐ Live birth	e of pregnancy 2 Fetal death	3 🗆	Ectopic pregnancy				23d.	Date of deli Month	ivery Day Year
e des	pe	Sici	1 ☐ Yes 2 🛇 No	4☐ Pregnant 9☐ Unknown	at time of death	5 🗌	Other (specify)					W.Orkir	Juy . Ju.
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Hospite 24 hours Funerel	Ž		29a. Certifier 1 Certifyin	ng Physician: To the bes	t of my knowledge	, death	occurred at the tin	ne, date a	nd place,	and due to the	cause(s) and	d manner as	stated.
the Hospitel nin 24 hours the Funerel	completely filled in	edical	(Check only 2 Medical one)	Examiner: On the basis and manner:	or examination and stated.	dor inv	estigation, in my o	pinion, dea	ath occurr	ed at the time,	date and pla	ce, and due	to the cause(s)
To the within 2	duoo	Ň	29b. Signature and title of cenifie	er n			29c. Licens	e number			29d. Date si	gned (Monti	h, Day, Year)
	- 1	H	Solve	enly Cert	-		H 4	69	61		11/2	5/11	
,			30. Name and address of person	who completed cause of	death (Item 23a) (Type, I	Print)		- '	0 0	1/ ~	44	E Rolling Cros
V			30. Name and address of person Soulome Heave	Kins-Cole	D.O. H	ea	Mand 1	HOSP	1ch	of Bal	timo	re,	Sucle 307
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jeseph State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ RICHARD JOSEPH ADAMEC Ottober 10:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Richar Cecil Point VA MARY LAND HEALTH CARESYSTEM Pen 6. Sex 1 M 2 D F If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Hours 69 Months 67-17-42 **Director** 138-34-8198 NY Adamec Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director MD Cecil 1 Yes 2 X No Rising Sun 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 775 Ragan Road 21911 USA items NAME KNOWN TO PHYSICIAN: 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married "natural", or Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 3 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Joseph Adamec Edith Jean Serrante 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank Ragan 775 Ragan Road Rising Sun, MD 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any injury or 1 🛣 Burial 2 🗌 Cremation 3 🗌 Removal from State Brookview Cemetery 10/26/11 Rising Sun, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 111 S. Queen Street R.T. Foard Funeral Home, P.A. Rising Sun, MD 21911 21. Signature of Funeral Service Licensel that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Colon Circinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter on certaining Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-transit pug that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ for in the past 12 months? Month Year Day Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury -Natural 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of a 29c. License number 29d. Date signed (Month, Day, Year) ish into H0654439 October 20,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IVA VA Maryland Healthcore System. Perry Paint. Mary land 21902 incur A. giminaro, DO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 25 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Parounag Arkoian 2011 October Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Rockville Shady Grove Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number Age (In yrs. last birthday) **Funeral** Nov . 6 1X M 2 | 1 Hours 1927 83 **Director** 577-34-3459 Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10a. State 10b. County death with the Maryland the Medical Examiner must be notified at Director MD Silver Spring Montgomery 11/05/01 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a 12601 Connecticut Avenue 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. ori þ 1 Never Married 2 Married 1 X Yes 2 No
If Yes, Give Korean
Year or Dates Conflict _{Specify}White within 72 hours after 21215-0036 1 ☐ Yes 2X No Specify. "natural", Completed 3 → Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene. Fitem 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Grocery Manager Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) Jan. 1981.

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Juge 1 and 2 is many injury or other. 17. Father's Name (First, Middle, Last) ပ Hngaper Keuroglian Levon Arkoian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 23538 Pocahontas Drive, Gaithersburg, MD 20882 Diane L. Scuderi/Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemetery 20a. Method of Disposition Date 0ct. 26 2011 1 ABurial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fineral Service Vicensee 22. Name and Address of Facility
Francis J. Collins Funeral
500 University Blvd. W., S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Fi ician/ ardiac arryth disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Respirato Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending the input of the Funeral director. severe acule Cause (Disease or iinjury 5 that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical card iomy IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown lastic 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ✓ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 🗌 Yes ပ 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural Accider work? 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Meliau Medical Our Dr Rockville MD 20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

11:40 p M

9. Birthplace (State or Foreign Birthpiac Country)

10d Inside City Limits

ng,MD 20901

Onset and Death

Dav

1 Yes 2 No

Year

1 🗌 Yes 2 🕱 No

DHMH 17 Rev 7/2009

State Registrar Fischatsion

9901

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Pleas 1 _ For State	State of Ma	ryland / Dep	artment of H	ealth and N	Лental Ну	giene	- 1 - 2
Physicia		Registrar 1. Decedent's Name (First, Middle, KENNETH		ALLEN	rtificate of D	eath	2. Date of Dea Month	Day	35472 3. Time of Death 1:05 P ^M
Medic Examin		4a. Facility Name (if not institution, g	give street and number)		4b. City, Town, or I	Location of Death	OCTOBER	18 2 4c. County	
Funeral		9200 EDWARDS 5. Social Security Number		(In yrs. last birthday)	ADEL	PHI If Under 24 Hrs.	Lo Barretti		CE GEORGE'S
Director		216-36-0050	1 X M 2 □ F	73 Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Day OCT. 8	Year) 1938	9. Birthplace (State or Foreign Country) NEW JERSEY
show dat	٦	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
Maryla 28a-f s ptified	recto	MD. PRINCE	GEORGE'S		ELPHI				1 XYes 2 No
1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number			10f. Zip Code	-	T	10g. Citizen of	What Country?
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fter de ", or its amine	by	1 Never Married 2 Marrie	A was and E C		If Yes, specify Cuban 1 Yes 2X No		Rican, etc.)		ce - American Indian, ck, White, etc.
ours a atural' cal Ex	Completed	3 Widowed 4 Divorced 15. Decedent'	Total of Button =	EIVA				Specify	WHITE
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be file ental F ked of	면 B	17. Father's Name (First, Middle, Las BYRON	ALLEN			18. Mother's Name			
should and M is mar		19a. Informant's Name/Relationship		19b. Maili	ng Address (Street an	BER			SAR State, Zip Code)
and 2 s tealth am 27 i			ALLEN/WIFE	9200	EDWARDS				
Page 1 a tment of H tant: If ite jury or ot		20a. Method of Disposition 1 Burial 2X Cremation 3 4 Donation 5 Other (Spe			osition (Name of matory or other place, CREMATOR)	Date 12011		- City or Town, State ALE, MD.
permit. Page Department of Important: If any injury or once.			anlugo	HOUUSI 5	2. Name and Address CHAMBERS F 801 CLEVE	LAND AVE	KTAE	KDALE . I	IUM,P.A. MD 20737
Physician/ Medical		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final disease or condition resulting in death)	ATHEROSC	he death. Do not ent	er the mode of dying, DRONARY AR	such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
Examiner		Sequentially list conditions,		consequence of): EMIA VERA					
nted d	Examiner	if any, leading to infined ate cause. Enter Underlying Cause (Disease or iinjury that initiated events	DIABETES	MELLITUS	TYPE II				
be ey sician buria	g	resulting in death) Last	·	consequence of): L HYPERTER	NSION				
tificate ng phy	Med	IF FEMALE:							
To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director.	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live Birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)				te of delivery onth Day Year
v requires that the de been signed by the should be detached	by P	Part II. Other significant conditions	contributing to death but	not resulting in the u	inderlying cause giver	n in Part I.	23e. Did tol	bacco use contr	ribute to the cause of death?
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or Attending Physician: The law in after death. Director: After this certificate has be in by the funeral director, page 2 still in by the funeral director, page 2 still be after the funeral director.	Completed						24a. Was a autops perform 1 X Yes	med?	Were autopsy findings available prior to completion of cause of death? 1 ▼ Yes 2 □ No
sician certifi irector	mί	25. Was case referred to medical examiner? 1 ☐ Yes 2 ₩ No	Hospital:		Othor	e of Death (Check			
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tendin leath. :or: Aff the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not	ion	/ear) injury	M 1 □ Ye	es 2 🗆 No			
or At after of Direct		4 Homicide determine		- At home, farm, stre Specify)	et, factory, office	1	28f. Location (St City or Town		er or Rural Route Number,
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completed filled in by the	Medical	Check Z L Medical Exa	nysician: To the best of my miner: On the basis of exar urse Practioner: To the be	Tilination and/or invest	ligation, in my opinion	death occurred at	the time date an	d nlace and due	ato the causeole) and manner stated
		29b. Signature and title of certifier		Kilowieuge, C	29c, License n		1		inner as stated. I (Month, Day, Year)
541		1	PSchrech	7.61	MD# 1:	1241		OCTOBER	20, 2011
		30. Name and address of person who GERALDINE SCHECH	TER. M.D., V		*	NW, WASH	INGTON,I	OC 20422	2/688
State	e	31. Date filed (Month, Day, Year) OCT 24 201	#2 Registrar's	Signature	_	-			
Registra	r	001 2 201	Senar	A. par					

DHMH 17 Rev 7/2009

			For State	State of Mary				Mental Hygi	ene	25172
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	tificate of L	Jeatn 	2. Date of Death	g. No. U	35473 3. Time of Death
ı	Physicia Medic		Dessie	Allene	В	oyd		Month Dealth	34 201	11 0405 M
	Examin	er	4a. Facility Name (if not institution, give st			4b. City, Town, or	Location of Deat	h	4c. County of Dea	
944	Funeral		Western MD Region 5. Social Security Number 6. Sex		Center yrs. last birthday)	Lif Under 1 Year	mberland If Under 24 Hrs			legany irthplace (State or Foreign
	Director		235-38-6002	M 2 💢 F 84	Yrs.	Months Days	Hours Min.		927 We	st Virginia
	od now	١	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or Lo	ation				
	farylar 8a-fst tified	Director	MD Alle			Cumberlan	d			10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	a or 2	ΙΩ	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	country?
	th with ms 23 must	Funeral	11213 Brown Hil				1502		USA	
(0	or iter		11. Marital Status 1 Never Married 2 Married	2. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🎇 No		Vas Decedent of H f Yes, specify Cuba	ispanic Origin? (S n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi	
8	urs aftu ural", il Exar	Completed by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.	1	☐ Yes 2 🗓 No	Specify:		Specify:	White
15-(72 hou n "nat ledica	nple	15. Decedent's Edu (Specify only highest grade	cation e co <i>mpleted)</i>	(Give I	lent's Usual Occup kind of work done o		rking 1	6b. Kind of Business	s Industry
712	vithin iene.		Elementary/Seconday (0-12)	College (1-4 or 5+)	life. Do	O NOT use retired) Homema	ıker		Home	
pu	filed val Hyg	Be (17. Father's Name (First, Middle, Last)					me (First, Middle, Ma	iden Surname)	
ylai	uld be I Ment narked natic e	입	Alby Lee		Cunningh	am	Bertl	na Vict	coria	Phillips
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type Roberta M. Carder					<i>iral Route Number, C</i> VE, Cumber	City or Town, State, Z rland, MD	Tip Code) 21502
ore,	e 1 an t of He If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		20b. Place of Dispo	sition (Name of natory or other place	e)	Date 2	0c. Location - City o	r Town, State
ij	it. Pag rtmen rtant: njury e		4 Donation 5 Other (Specify)						LaVale, N	
Ba	permir Depar Impor any in		21. Schatur, of Funeral Service ricensee	2006		Name and Addres OH Decat			y Funeral erland, MI	Home, P.A. 21502
			23a. Part 1. Enter the disease, or complications, or heart failure. List only one	cations that caused the cause on each line.	death. Do not ente	r the mode of dyin	g, such as cardiad	or respiratory arrest		Approximate Interval Between
	Physician Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	DS 15					Onset and Death 2 weeks
41.474	Examiner		Sequentially list conditions, b	Due to (or as a ove	sequence on.					
	sit sit	dical Examiner	if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence of):					
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09	ate be executed physician and the burial-transit	lical	L _d							
876	tificating bh	Med	IF FEMALE:						-10	
9 XC	ath cel attendi for use	cian/	23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of portion 1 Live Birth 2 4 Pregnant at time	Fetal death 3	Ectopic pregnanc	у		23d. Date of de Month	elivery Day Year
P.O. Box 687	the dearly the a	Physician/Me	1 Yes 2 No 9 Unknown	9 Unknown	e or death 5 L	Other (specify)			Worth	Day Toal
<u>P</u>	s that i	by	Part II. Other significant conditions conf	tributing to death but no	ot resulting in the u	nderlying cause giv	en in Part \.	23e. Did toba	cco use contribute t	to the cause of death?
rds,	een się	ted						1 🗌 Yes	2 □ No 3 □ I	Probably 4 nknown
eco	e law n has b ge 2 sk	Completed				-		24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
Ē.	in: The		25. Was case referred to medical			26 DI	ace of Death (Che	1 Yes 2		es 2 🗆 No
Vita	nysician: Tassicians of the control	To Be	examiner? 1 Yes 2 No	ospital:	2 ER/Outpatien	Oth	er:		ce 6 Other (Spe	cife)
of	ing Ph		27. Manner of Death Natural 5 Pending	28a. Date of injury (Month, Day, Ye.	28b. Time of	28c. Injury work	at	28d. Describe how		City)
sior	ottendi death ctor: A y the fi	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury -	At home farm stra		Yes 2 No	005 1		
Division of Vital Records,	tal or A		4 Homicide determined	building, etc. (S	pecify)	et, factory, office		City or Town,	et and Number or Ri State)	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check 2 Medical Examine	r: On the basis of exami	nation and/or invest	idation. In my opinic	 n. death occurred. 	at the time date and	place and due to the	cause(s) and manner stated
	To the vithin To the compl		only one) 3 L Certifying Nurse 29b. Signature and title of dertifler	Practioner: To the best	or my knowledge, d	29c. License	number	290	d. Date signed (Mon:	th, Day, Year)
	2		> pob	~			33280		Oct 24,	2011
	MAN		30. Name and address of person who cor Sunil K. Gupt	npleted cause of death a, M.D., ((Item 23a) (Type, P 525 Kent	Avenue,	Cumberla		1502	
	Stat	е	31. Date filed (Month, Day, Year) OCT 24 201	32. Pegistrar's S	Signature	- 41				
	Registra	ir	00127201	Denena	A. A.	aver-				

			For State	State o	f Maryland						2	0 1	25171
			Registrar	o Local		Cer	incate	of Deati	· · · · · · · · · · · · · · · · · · ·	2. Date of Dea	leg. No.	ULL	3 5 4 4
	Physicia Medic		Decedent's Name (First, Middle Fonda	Beth Bran	nan					october		20 1	3. Time of Death B 30 P _M
	Examin		4a. Facility Name (if not institution	n, give street and num	ber)			wn, or Locati Freder:			4c. Co Fr	unty of Deat	th CK
			Frederick M 5. Social Security Number		7. Age (In yrs. la:	at hirthday)	If Under 1		der 24 Hrs.	8. Date of Birth		g Rir	thplace (State or Foreign
	Funeral Director		439-96-6113	1 M 2 XF	45	Yrs.		Days Hou		(Month, Day 07/25/	Year) 1966	Co	untry) isiana
			Usual Residence of Decedent										10d. Inside City Limits
	yland f shc ed at	횽	10a. State 10b. County		10c. City	, Town or Loc							1 Yes 2 No
	e Mar 28a- notifi	Director	MD Fr	<u>ederick</u>		Monr	ovia	ode.			10g Citizo	n of What Co	
	ith th	ral	3538 Runkles	Daire			1	21770				ed Sta	
	ems r	Funeral	11. Marital Status	12. Was Dece	dent Ever in U.S	. 13. V	Vas Deceder	nt of Hispanic	Origin? (Spe	cify Yes or No-			erican Indian,
)	or its	by F	1 Never Married 2 Ma	Armed For	2 X No			Cuban, Mex		Rican, etc.)		Black, Whit ecify: Wh	
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ν <u>Σ</u>	led w Hygi other ent, t	Be (17. Father's Name (First, Middle,	Last)		-		18. M		(First, Middle,			
Ö	d be fi dental irked tic ev	욘	Medgar Fin	ley					Tuna A	likadio	gulla	ari ———	
2	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations			ı				Route Number			
≥ 1`	and 2 lealth sm 27 her tr		Richard Filom	ena / comp						Monrovia	· .		r Town, State
2	ge 1 and to the true of the corot		20a. Method of Disposition 1 🔲 Burial 2 💢 Cremation			lace of Dispo emetery, cren		ar alagal)1/2011		-	
Dallillor	iit. Parartmer artmer ortant njury		4 ☐ Donation 5 ☐ Other (31111	LIISDUI	Name and	Address of F	acility Kee	nev &	asfor	d Fun	eral Home
מ	permit Depar Impor any in once.		asulu	brech) MO122	22 1	L06 E.	Churc	h Stre	et, Fre	ederio	ck, MD	21701
			23a. Part 1. Enter the disease, o	r complications that of	caused the death	n. Do not ente	er the mode	of dying, such	n as cardiac c	r respiratory arr	est,		Approximate Interval Between
	nysician/	6.5	shock, or heart failure. List Immediate Cause (Final disease or condition	only one cause of ea	10%C 6	ncelo	Matz	Vaj					nser and Death
	Medical		resulting in death)	a. Due to	or as a consequ	ence o l:	Jan	9					7 /
	Examiner	<u>_</u>	Sequentially list conditions,	b. YE	H MT	cst							1 days
	ed sit	m in	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	M	HiloLa	bos	troal	phe	umov	n'a			89 days
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2	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dical Examiner		d									
00/00	tificate ng phy as th	Med	IF FEMALE:										
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DOX	e dea the a	Completed by Physician/Me	1 Yes 2 No	4 ☐ Preg g ☐ Unki	nant at time of d nown	leath 5 L	Other (spe	GIIY)					
, S	hat th ed by detac	y Ph	Part II. Other significant condit	ions contributing to d	eath but not res	ulting in the u	nderlying ca	use given in I	Part I.	23e. Did to	bacco use	contribute t	to the cause of death?
S,	uires t n sign ild be	q pe								1 🗆 1	Yes 2	No 3 🔀 I	Probably 4 🗆 Unknown
ecoras,	w requ	plet								24a. Was	nsv		utopsy findings available completion of cause of
160	The la ate ha bage 2	S m								perfo	rmed? 2 No	death?	es 2 No
VITAII K	cian; ertifica ector, I	Be (25. Was case referred to medica examiner?	Hospital:					Death (Checi	k only one)			
<u> </u>	Physic this c	ျ	1 Yes 2 No	1 28a. Date	npatient 2	ER/Outpatie		Other: 4 [c. Injury at		ome 5 Residence 128d. Describe h			ecify)
n 01	ding l h. After funer	Certificate:	1 Natural 5 ☐ Pend	/// / / / / / / / / / / / / / / / / / /	th, Day, Year)	injury	м 20	work?		20d. Describe i	ow injury c	ocurred	
210	Atten r deal sctor: by the	ij	3 Suicide 6 Coul	d not be 28e. Place	of Injury - At ho		eet, factory,	office				Number or R	ural Route Number,
DIVISION	s afte		I	build	ing, etc. (Specify	,				City or Tow	n, State)		
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical	ng Physician: To the b Examiner: On the bar ng Nurse Practioner:	sis of examination	and/or inves	tigation, in m	v opinion, dea	ath occurred a	t the time, date a	ind place, a	nd due to the	e cause(s) and manner stated.
	o the	Σ	only one) 3 \(\subseteq\) Certifyir 29b. Signature and title of certifi	er			29c.	License num	ber	ce, and due to the			oth, Day, Year)
	- > - 0		> Mm	Morius N	Effice M	U	3	5729	77		10,	130/2	2011
	,		30. Name and address of person	who completed caus	se of death (Item								
			31. Date filed (Month, Day, Year)	Neslin	A Cor Registrate Signal		74n S	t. tr	eder	ick, n	OD 8	21701	
	Sta Registr		NOV 0 7 201	1 Denvin	registrants Signal	Dank	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35475 Certificate of Death Decedent's Name (First, Middle, Last) ELIZABETH FLORENCE 2. Date of Death 3. Time of Death Physician/ OCTOBER 21 beth 20 1 03:39 AM (AKA) BLAKELEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** CECIL UNION HOSPITAL OF CECIL COUNTY ELKTON 5. Social Security Number If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2XX Months Days Hours Min. SEPT. 13,1920 PENNSYLVANIA 213-20-9510 91 Director Usual Residence of Decedent Show . Page 1 and 2 should be filed within 72 hours after death with the Maryland irrent of Health and Mental Hygiene. Tant: If item 27 is marked other than "natural", or items 23a or 28a-f shor jury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location Director 1 😾 Yes 2 🗆 No CECIL MARYLAND ELKTON 10e. Street and Number 10f. Zip Code 10q. Citizen of What Country? Funeral 150 EAST MAIN STREET, APARTMENT 410 21921 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 Yes 2 No Specify. Specify: 3XXWidowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ FRED SCOFIELD MABEL BULLOCK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>JAMES N. BLAKELEY / SON</u> P.O. BOX 414, NORTH EAST, MARYLAND Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specific 5 Other (Spec BAY VIEW CEMETERY BAY VIEW, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, PA Signat 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND 21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPSIS Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner CAMDIOM Sequentially list conditions, it arry, each glo immediate cause. Enter Underlying Examiner CORONARY Cause (Disease or linjury ARTER and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Por in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 9 Unknown should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Winknown 1 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 perform 1 ☐ Yes 2 ☐ No After this certificate Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be 2 No ပ္ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 10/21/11 Naye De 40 00065733

State Registrar A. BAST

HIGH

STYLLET

126

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 0CT 2 4 2011

V-PULA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of F rtificate of L			leg. No. 0	35476
	Physicia	ın/	1. Decedent's Name (First, Middle,	Last)		<u> </u>		2. Date of Deat	th	3. Time of Death
	Medic	cal	Claribel 4a. Facility Name (if not institution,	Bethke		4. 07. 7	The state of the state of	October		
	Examin	ier	Spring House	,		Bethesda	Location of Death		4c. County of De Montg	1
Т	Funeral		5. Social Security Number		(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	g	Birthplace (State or Foreign
	Director		Usual Residence of Decedent	1 - WI 2 - 25	93 Yrs.			April 19	, 1918	Panama
	show dat	tor	10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	Mary 28a-1	Jirec		tgomery	Bethe					1 ☐ Yes 2 🛣 No
	ith the 23a or st be r	Funeral Director	10e. Street and Number 4925 Battery La	no #806		10f. Zip Code 20814			10g. Citizen of What USA	Country?
	eath w	-une	11. Marital Status	12. Was Decedent Ev		Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-		merican Indian,
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 🙀 Marr 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ I If Yes, Give Year or Dates.	lo.	f Yes, specify Cuba			Black, W Specify: W	
<u>2</u> -0	"2 hou "natu edical	Completed	15. Deceden (Specify only higher	t's Education st grade completed)	(Give	dent's Usual Occup kind of work done o		king	16b. Kind of Busine	ss Industry
72	vithin 7 iene.	Con	Elementary/Seconday (0-12)	College (1-4 or 5-	F)	O NOT use retired) les Accou	ntant		Clothier	
b	filed wall Hyg	Be c	17. Father's Name (First, Middle, La	ast)		res neced		ne (First, Middle, M		
ylaı	Menta Menta narked	ပ	Edward McDona				Delia	de Soto		
Mar	2 shouth and the and 27 is nutraum	ı	19a. Informant's Name/Relationsh Averell Dale E						City or Town, State, esda, MD	
ē,	1 and of Heal item 2		20a. Method of Disposition		20b. Place of Dispo	sition (Name of		Date	20c. Location - City	
<u>E</u>	Page nent c ant: If ury or		1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		Parklawn	matory`or other plac Memorial	;	t. 25, 2011	Rockville	, MD
Balt	permit. Departr Import any inji		21. Signature of Funeral Service Li	cense	22	Name and Address Francis J 000 Unive			1 Home In	c. ring,MD 20901
П			23a. Part 1. Enter the disease or shock, or heart failure. List of	complications that caused aly one cause on each line.	the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	hysician/	0.1	Immediate Cause (Final disease or condition resulting in death)		r's Disea	se				Onset and Death 4 years
	Medical Examiner		resulting in death)	Due to (or as a	consequence of):					
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):					
	onted g	Examiner	cause. Enter Underlying Cause (Disease or imjury that initiated events	с						
_	icate be executed in the purial case is the burial case.	al E	resulting in death) Last	Due to (or as a	consequence of):					
09/	icate t g phys is the l	fedical		d						
89 89 89	n certif ending use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o	of pregnancy	Ectopic pregnanc	24		23d. Date of	delivery
Ω Ω	s death the att	/sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at 9 Unknown		Other (specify)	· y		Month	Day Year
P.O. Box	at the ed by t detach	/ Ph	Part II. Other significant condition	ins contributing to death bu	t not resulting in the u	ınderlying cause giv	en in Part I.	23e. Did tob	pacco use contribute	to the cause of death?
S,	uires tl n signa Ild be	ed by	Hypertension					1 □ Ye	es 21 No 3	Probably 4 🗆 Unknown
Š	iw required is bee 2 shou	Completed						24a. Was ar		autopsy findings available to completion of cause of
ě	The la ate ha	Com						autops perform 1 \(\sime\) Yes	ned? death	
<u>ta</u>	sician: The la certificate ha irector, page 2	Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		Othe	ace of Death (Chec		yAcci.	stad I fudna
010	g Physer this eral di	e: To	27. Manner of Death	28a. Date of injury		128c. Injun	/ at		ence 6 1 Other (5) w injury occurred	sted Living
O	ending sath. or: Afte he fun	ficat	1 Natural 5 Pending 2 Accident Investig	ation	Year) injury	M 1 □	? Yes 2□No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burian to the funeral director, page 2 should be detached for use as the burian to the funeral director.	Certificate:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		y - At home, farm, str (Spec <i>ify</i>)	eet, factory, office		28f. Location (Str City or Town		Rural Route Number,
_	fospit: 4 hours uneral ed fille.	Medical	29a. Certifier 1 Certifying 2 Medical Ex	Physician: To the best of m	ny knowledge, death o	occured at the time,	date and place, an	nd due to the caus	se(s) and manner as	stated. ne cause(s) and manner stated.
	the Pithin 2, the Formplet		only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the b	est of my knowledge,	death occurred at the	e time, date and pla	ce, and due to the	cause(s) and manner	as stated.
	²		5	L. Shapir.		D353			9d. Date signed (Mo	
	, ,		30. Name and address of person w						JUDDET Z.	-, 2011
			Deena J. Shapi		10 Connect	icut Ave	nue, Kens	sington,	MD 20895	
	Stat Registra	e er	31. Date filed (Month, Day Year) 2(32. Registrar	's Signature	ted.				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35477 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Alberta 2300 Omith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland medical Center Baltimore Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Hours Min (Month, Day, Mary land Director Department of Health and Mental Hygiene. Important: yor items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 No nrch ester 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 4P a Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) ည e 1 and 2 should b t of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) worth Ct. Apt. 102 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility
Henry Funeral Home,
FIG Washington St 21. Signature of Funeral Service Licensee St. Cambrid 21613 anelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Exsurgion eten 6 hours disease or condition Medical resulting in death) Due to (or a consequence of) **Examiner** Biventricular le hours Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No ed by the a detached 1 9 Nuknown P.O. signed by t t be detach Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mitral Regurgitation Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Coronery Diservi 24a Was an has performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🗶 No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Investigation
6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct, 22, 2011 K115989 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Green Street, Baltimore, MD Williams 31. Date filed (Mo Registrar's Signatur State Registrar

		State of Maryland / Department of Health and Mental Hygiene Certificate of Death State Reg. No. 20 35478
		1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death
Physic Med	ian/ lical	George Henry Brannock October 1548 M
Exam	iner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Cambridge 4c. County of Death Dorchester
Funera Directo		5. Social Security Number 1 Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 8. Days Hours Min. Sept. 14, 1934 9. Birthplace (State or Foreign Marry) and 9. Birthplace (State or Foreign Marry) and
and show	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
Maryla 28a-f	Director	MD Dorchester Cambridge 1 □ Yes 2 🗷 No 10e. Street and Number 10g. Citizen of What Country?
* S23a or ust be a	Funeral D	10e. Street and Number 5315 Skipjack Drive 10f. Zip Code USA 10g. Citizen of What Country? USA
Baltimore, Maryland 21215-0036 Permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	ted by Fur	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No Specify: 14. Race - American Indian, Black, White, etc. Specify: 15. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, Specify Yes or No-If Yes Yes or No-If Yes Yes or No-If Yes Yes Yes or No-If Yes Yes or No-If Yes Yes Yes or No-If Yes Yes Yes or No-If Yes Yes Yes or No-If Yes Yes Yes Yes
21215-0036 within 72 hours afte giene. er than "natural", c	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+) College (1-4 or 5+)
land 2- be filed wit ental Hygie ked other	To Be C	17. Father's Name (First, Middle, Last) Edward DeWitt Brannock 18. Mother's Name (First, Middle, Maiden Surname) Susie Aaron
Maryland Maryland 12 should be filed ath and Mental Hy 27 is marked out		19a. Informant's Name/Relationship (Type, Print) Glenn G. Brannock son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3548 Ocean Gateway, East New Market, MD 21631
Baltimore, Ma bernit. Page 1 and 2 sho bepartment of Health and mportant. If item 27 is 1 my injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/24/11 Cambridge, MD
Baltii Permit. F Departm Importa	ouce	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomas Funeral Home P.A. 700 Locust St., Cambridge, MD 21613
→ F⊓ysician Medica		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):
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Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completed filled in by the funeral director, page 2 should be detached for use as the	Completed by Physician/Mec	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Ves 2 No 9 Unknown Unknown 23c. If yes, outcome of pregnancy 1 Etive Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year Ye
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n of \\ ding Phy h. After this	sate: Te	27. Manner of Death 1 Natural 5 Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28c. Injury at work? 28d. Describe how injury occurred
Division If or Attents after deat Director:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be determined 4 Homicide Could not be determined Sale. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
E Hospita n 24 hours ne Funeral	Medical	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
To th		29b. Signature and title of certifier Ahmed Cabib ND 29c. License number D 65528 29d. Date signed (Month, Day, Year) 10 19 20
•		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21613.
S Regis	tate trar	31. Date filed (Month, Day, Year) OCT 2 4 2011

		-	For State Registrar	State of M	aryland /	•	nt of Hean te of Deat	n and Meni h		2011	35479
F	Physicia Medic		1. Decedent's Name (First, Middle W) [[] Wh	1 0	har	ran			ate of Death	Day / 2 Year	3. Time of Death
F	Examin		4a, Facility Name (if not institution LIUGTS KILD 5. Social Security Number 399-20-2129	11wood 1	last b	000		SVIII (eate of Birth	4c. County of Dear	thy Avun def thplace (State or Foreign untry) WI
	show tab	l 1	Usual Residence of Decedent 10a. State 10b. County		81 10c. City. To	own or Location		1 1	/31/19	30	10d. Inside City Limits
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21215-0036 within 72 hours after death with the Maryland	or results and welfare hyperical ryperical center of items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	by Funeral Director	504 Saltoun Av 11. Marital Status 1 □ Never Married 243 Mar	12. Was Decedent B	Ever in U.S. No. 1947	_		Origin? (Specify Yolican, Puerto Rican,	es or No-	14. Race - Ame Black, Whit	e, etc.
003	tural", al Exar	ted t	3 Widowed 4 Divorced	If Yes, Give Year or Dates.	67	1 Yes	2 [™] No Spe	cify:		Specify:	White
72 ho	ın "nat Medica	Completed	(Specify only highe	nt's Education est grade completed)		6a. Decedent's Us (Give kind of w life. DO NOT us	ork done during i	most of working	16	b. Kind of Business	Industry
Withir 21	ygiene her tha t, the		Elementary/Seconday (0-12)	College (1-4 or 5)+)	Enlist				US Navy	7
Maryland 21215-0036 2 should be filed within 72 hours after	ked otl	To Be	17. Father's Name (First, Middle, I Edward Buchana					lother's Name <i>(Fir</i> s) e 11ie Hi1			
Maryland Should be file	s mark		19a. Informant's Name/Relations		Į į	9b. Mailing Addres				ty or Town, State, Zi	p Code)
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imore Page 1 a	nt: If ite y or ot		20a. Method of Disposition XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (3)		ceme	e of Disposition (Na etery, crematory or Land Vete	other place)	Date n. 10/17/	- 1	c. Location - City or Crownsvil	
Baltimore,	Important: If it any injury or conce.	Ī	21. Signature of Funeral Service I		, maryi	22. Name a		acility Hardes	ty Fun	eral Home MD 21401	P.A.
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ox 68760 ath certificate be executed	attending physician and for use as the burial-transit	/Medical	resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as d	2 Fetal de	eath 3 🔲 Ectopic				23d. Date of de	blivery Day Year
P.O. Box that the death of	by the a	Physic	1 Yes 2 No 9 Unknown	9 🗆 Unknown							
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Division of Vital Records, tal or Attending Physician: The law requires after death.	To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a	Completed	05. W						24a. Was an autopsy performe	prior to death?	atopsy findings available completion of cause of
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on of ending Ph	I Director: After this ad in by the funeral d		27, Manner of Death 1 Natural 5 Pendir 2 Accident Investi	28a. Date of inju (Month, Daggation	ry 28b	o. Time of injury M	28c. Injury at work? 1 □ Yes	28d. [injury occurred	
Jivisi al or Att	I Directord in by t		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ			farm, street, facto	ry, office		ocation (Stree ity or Town, S	et and Number or Ru State)	ıral Route Number,
Le Hospit	ne Funera	Medical	(Check 2 Medical I	Physician: To the best of Examiner: On the basis of e Nurse Practioner: To the	xamination and	d/or investigation, in	my opinion, dea	th occurred at the ti	me, date and p	place, and due to the	cause(s) and manner stated.
J Z	\$ 000 X		29b. Signature and title of certifie	& 11 Cl	usc	_ P	c. License numb	5891	290	I. Date signed (Mont	h, Day, Year)
约	53		2007 Tiden	who completed cause of d	eath (Item 23a	a) (Type, Print)	#/A	Anna	polis	mo	21401
	Stal Registra	.e	31. Date filed (Month, Day, Year) OCT 2 (ar's Signature	1. park	1				

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

.i.a/	State Registrar 1. Decedent's Name (First, Middle, Last)	Ce	rtificate of Death	2. Date of Dea		35480
cian/ dical	CLARA ELIZABETH COLEMA	<u> </u>	T	OCTOBE		11:00 a ^M
niner	4a. Facility Name (if not institution, give street and numb 25750 Collins Ave.	er)	4b. City, Town, or Location of E Chestertown	Peath	4c. County of Death Kent	
al or	5. Social Security Number 220-03-6004 Columbia	. Age (In yrs. last birthday) 92 Yrs.	If Under 1 Year If Under 24 Months Days Hours I	Hrs. 8. Date of Birtl Min. Jan 8		nplace (State or Foreign Tand
tor	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
Director	MD Kent	Chester				1 Yes 2 XNo
Funeral D	10e. Street and Number 25750 Collins Ave.		10f. Zip Code 21620		10g. Citizen of What Cou U.S.A.	intry?
	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 12. Was Deceded Armed Force 1 ☐ Yes 2 if Yes, Give Year or Date	es? No	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White, Specify: With	
Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4)	or 5+)	dent's Usual Occupation kind of work done during most of DO NOT use retired)	working	16b. Kind of Business Ir	•
Be C	17. Father's Name (First, Middle, Last)	Lab	Technician 18. Mother's	Name (First, Middle, I	Chemical C	Company
요	Marion Milton Ireland		371	ie Lewis J		
	19a. Informant's Name/Relationship (Type, Print) Robert Coleman (son)	204		r Rural Route Number stertown, M	D. 21620	
	20a. Method of Disposition 1 ☑ BurjaL 2 ☐ Cremation 3 ☐ Removal from S 4 ☐ Donation 5 ☐ Other (Spenty)		matory or other place)	Date 1/2/11	20c. Location - City or 1 Chestertow	
ouce.	21. Signature of Juneral Service Licenses	M00510	2. Name and Address of Facility Galena Funeral H 18 West Cross S	ome of Ste t. Galena	ephen L. Sch	aech
n/ al er	Sequentially list conditions, b. ——	RYOSCUY		diac or respiratory arr	est,	Approximate Interval Between Orset and Death
edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	as a consequence of):				
Physician/Medi	in the past 12 months?	ant at time of death 5	Ectopic pregnancy Other (specify)		23d. Date of deli	very Day Year
∂ Σ	Part II. Other significant conditions contributing to dea	ath but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to the	the cause of death?
Completed			//		rned? prior to content?	opsy findings available ompletion of cause of
BB	25. Was case referred to medical examiner?		26. Place of Death (· · · · · · · · · · · · · · · · · · ·		
<u>은</u>	1 ☐ Yes 2 2 No 1 ☐ Ir 27. Manner of Death 28a. Date of		ent 3 L DOA 4 L Nursi		ence 6 Other (Specif ow injury occurred	5y)
licate	2 Accident Investigation	Day, Year) injury	work? M 1 ☐ Yes 2 ☐ No		,,	
l Certificate:		f Injury - At home, farm, sti , etc. <i>(Specify)</i>	reet, factory, office	28f. Location (S City or Town	treet and Number or Rura n, State)	al Route Number,
Medical	29a. Certifier (Check 2 Medical Examiner: On the bessonly ope) 3 Certifying Nurse Practioner: To	of examination and/or inves	stigation, in my opinion, death occu	rred at the time, date ar	nd place, and due to the ca	ause(s) and manner stated
	29b. Signature and title of certifier	mo	29c. License number D /64 C) 9	29d. Date signed (Month,	lay, Year)
7	30 Name and address of person whe completed cause	of death (Item 23a) (Type,	Print)		120	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Patrick Coyne, 201°1 October 1:40 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 8. Date of Birth (Month, Day, Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs, last birthday) 9. Birthplace (State or Foreign Days Hours 1X M 2 - F **Director** 68 D.C. 578-56-3879 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Montgomery 1 Yes 2 No Silver Spring 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 901 Arcola Avenue 20902 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian. or Completed by 1 Never Married 2 Married 1X Yes If Yes, Give within 72 hours after 2 🔲 No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify and Mental Hygiene.
is marked other than "natural", 3 Divorced 4 Divorced Year or Dates. 1969-72 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Patrick Coyne, Sr. Anne Barbara Corrigan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Mary Coyne/Sister Devils Elbow, Diamondhead, MS 39525 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State injury or 26, 0ct. 2 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility Francis J. Coll 500 University ins Funeral Home Inc Blvd. W., Silver Spring, MD 20901 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardial Infarction Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): 3 Cause (Disease or linjury that initiated events resulting in death) Last that the death certificate be executed Diabetes Mellitus Due to (or as a consequence of) nding physician use as the burial Physician/Medical IF FEMALE use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year signed by the at d be detached fo Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 2 K No Yes or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, To the Hospital or Attending Phys
within 24 hours after death.
To the Funeral Director: After this of completed filled in by the funeral dil 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Records.

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

Daniel K. Sherk, MD

31. Date filed (Month, Day)

D67355

1500 Forest Glen Road, Silver Spring, MD 20910

29d. Date signed (Month, Day, Year)

October 22, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 2011 1635 РΜ Clark Cooper Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Elkton Care and Rehabilitation E1kton Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 🗓 M 2 🗆 F Country) Virginia Months Days Hours Min. **Director** 227-40-0246 1935 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 236 Locust Lane 21921 United States within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. Yes 2 X No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify. Specify: 3 X Widowed 4 Divorced Completed White Year or Dates and Mental Hygiene.
I is marked other than "natur raumatic event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Electrical Motor Elementary/Seconday (0-12) College (1-4 or 5+) Die Caster Manufacturing Be should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Guy Cooper Hazel Blankenship 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie S. Handlin/Granddaughter 311 Hollingsworth Manor, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November 2. Gilpin Manor Memorial Park ö 1 X Burial 2 Cremation 3 Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) 2011 Elkton, MD 22. Name and Address of Facility Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licenses 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due lo (or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence oi). To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 2 No should be detached g Unknown 9 Unknown ned by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? sign 3 Probably 4 Unknown 1 Yes 2 No 200100 peen 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? has director, page 2 performed certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Dother (Specify 24 hours after death.
Funeral Director: After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending 1 Tyes М Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier who mpleted cause of death (Item 23a) (Type, Print) Main

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

201

32. Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35483 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10/19/2011 Forrest W. Carson, Sr. 12:39 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe **Funeral** 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign 256-34-5185 (Month. Dav. Year) 1 🖁 M 2 □ F Director Usual Residence of Deced 82 Feb. 19, 1929 Georgia 28a-f show 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Maryland Prince George's Bowie 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 3119 Belair Drive 20715 USA items permit. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 A Yes 2 No. 1 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married "natural", or 1 M Yes 2 1 No. If Yes, Give 1948-1974 Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify: White 3 Widowed 4 Divorced Completed is marked other than "natu aumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) and Mental Hygiene. College (1-4 or 5+) \$atellite Communications Goddard NASA 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ W. Paul Carson, Sr. Florence Lee Stone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 Department of Health Important: If item 27 any injury or other tr 2009 Knollwood Lane Carrollton, TX 75006 Forrest W. Carson, Jr./ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Mary Land Veterans Cemetery 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/25/2011 | Crownsille, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last signed by the attending physician be detached for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Year Month Day Pregnant at time of death Unknown 9 Unknown Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performe within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 2 🗌 No Yes 2 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 **2**No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Dea 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year

OCT 21

strar's Signature

JB Cobb	State of Maryland / Department of Health and No. 1-For State Certificate of Death		2011 3548		
Physician/ Medical Examiner	1 1. Decedent's Name (First, Middle,Last) J.B. Cobb	2. Date of Death Month October 16	Day Year 2015 hrs		
	4a. Facility Name (if not institution, give street and number) Baltimore Washington Medical Center 4b. City, Town, or Loc Glen Burnie 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year		4c. County of Death Anne Arundel (MM/DD/YYYY) 9. Birthplace (State or		
Funeral Director	450-52-0192 1 X M 2 F 73 Yrs. Months Days	f Under 24Hrs. 8. Date of Birth Hours Min. 11/02/	Foreign Toyac		
Aaryland 23a-f show any 1 at once,	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location MD Anne Arundel Pasadena		10d. Inside City Limits 1 Yes 2 X No		
the Marylands or 28a-f sh	10e. Street and Number 135 Magothy Beach Road 21122		g. Citizen of What Country? USA		
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. Inst. If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatie event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	or Dates: 1975 1 Yes 2 X No st		White, etc. Specify: White		
5-0036 lied within 72 hours lied within 72 hours last Hygiene. 4 other than "nature the Medical Exame the Medical Exame the Completed"		NOT use retired)	16b. Kind of Business/Industry Draperies Installation		
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	Jessie Cobb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street an	Mother's Name (First, Middle, M Stella Foulsom d Number or Rural Route Numb			
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumating or other	Beulah Cobb / Wife 135 Magothy Be 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 135 Magothy Be 20b. Place of Disposition (Name of cemete crematory or other place) MD Veterans Cemeter	ory, Date October 21,	ena, MD 21122 20c. Location - City or Town, State Crownsville, MD		
Balti permit. Departu Importi injury o	21. Signature of Funeral Service Licensee 22. Name and Address of Barranco & S 495 Ritchie	Facility Ons, P.A. Seve	rna Park Funeral Home		
Physician //Medical Examiner	23a. Part (Enter the disease, or complications that caused the death. Do not enter the mode of dying, such failure. List entry one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Ruptured Thoracic Aneurysm Due to (or as a consequence of):	h as cardiac or respiratory arre	st, shock, or heart Approximate Interval Between Onset and Death		
ted Insit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Hypertensive Atherosclerotic Cardiovascular Disease to the to (or as a consequence of): Due to (or as a consequence of):	se			
D, be execus sician and nurial - tra	UNPENDED AMENDED				
b. Box 6876(the death certificate by the attending phy ched for use as the te	FFEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E 23c. If yes, outcome of pregnancy 1 Live birth 2 E 23c. If yes, outcome of pregnancy 1 Live birth 2 E 23c. If yes, outcome of pregnancy 1 Live birth 2 E 23c. If yes, outcome of pregnancy 1 Live birth 2 E 23c. If yes, outcome of pregnancy 1 Live birth 2 E 23c. If yes, outcome of pregnancy 1 Live birth 2 E 23c. If yes, outcome of pregnancy 2 23c. If yes, outcome of pregnancy 2 23c. If	Ectopic pregnancy	23d. Date of delivery Month Day Year		
s, P.O. lires that the signed by the detache			acco use contribute to the cause of death? 2 ✓ No 3 Probably 4 Unknown		
Records, The law require ficate has been sign, page 2 should be Completed		24a. Was ar autops perform 1 ✓ Yes 2	y prior to completion of cause of death?		
Division of Vital Records, P.O. Box 6876i the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending phy uppletely filled in by the funeral director, page 2 should be detached for use as the Lilical Certification: To Be Completed by Physician/Mi	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other	: Work? 28d. Describe ho	tesidence 6 Other:		
Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After the funeral director of the funeral director after the funeral director after the funeral director of the funeral direct	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building (Specify)	ing, etc. 28f. Location (St or Town, Sta	reet and Number or Rural Route Number, City ate)		
To the Hospital within 24 hours To the Funcral completely filled	Certifying Physician: To the best of my knowledge, death occurred at the time, date a one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, decay and manner stated.	ath occurred at the time, date a	nd place, and due to the cause(s)		
2	Vieto Vitter Veet 700.C.M.E		29d. Date signed (Month, Day, Year) October 17, 2011		
454		et, Baltimore, MD 21223	3		
State Registrar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DONALD DEAN DYCHE Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Allegany Western MD Regional Medical Center Cumberland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Min. 232-60-5494 Hours 04/10/1941 Mary Land 70 Director Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director WV Mineral Ridgeley 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Route 2, Box 551 26753 U.S.A. 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces:

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 X Married 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. '59-'61 Specify: Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Pilgrim's Pride Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Helen Canan Donald Dyche 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores F. Dyche / Wife Route 2, Box 551, Ridgeley, WV 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 \square Burial 2 $\cancel{\mathbf{X}}$ Cremation 3 \square Removal from State cemetery, crematory or other place) Cumberland Crematory 10/23/201 4 ☐ Donation 5 ☐ Other (Specify) Cumberland, MD P.O. Box 1260, Fort Ashby, WV 26719 21. Signature of Funeral Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death -Physician/ farclus Medical resulting in death) Examiner goni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ► No 24a. Was an autopsy performe Yes 2 N Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{Nursing Home}} \) 1 \(\text{Residence} \) 6 \(\text{\text{\text{O}}} \) Other (Specify) မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA after death. Director: After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 1 Natural 28d. Describe how injury occurred 5 Pending injury 2 🗌 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check the 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

2

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 27 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Darke

Adealan Enkeshafi, M.D.-12500 Willowbrook Road, Cumberland, MD

29c. License number

29d. Date signed (Month, Day, Year) 10/20,11

			State of Ma	•	partment of Hea		lental Hygie	ene	
			Registrar 1. Decedent's Name (First, Middle, Last)	C	ertificate of Dea	ath		g. No.20	35486
	Physicia		BETTY LOUISE DAWSON				2. Date of Death Month	Day Year 19 2011	3. Time of Death 6:25 P. M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc	cation of Death	1_10	4c. County of Deat	
			Allegany Health, Nursing &					Allegan	
	Funeral Director		5. Social Security Number 6. Sex 7. Age 1 ☐ M 2 🖫 F	e (In yrs. last birthda) 89 Yrs.	Months Davs H	Under 24 Hrs. lours Min.	8. Date of Birth (Month, Day, Yo 05/19/19	ear) 9. Bir Co	thplace (State or Foreign untry) t Virginia
7	ow t	L	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or			05/15/12	22 11100	T .
ne ve	a-fsh fied a	Director	MD Allegany	Cumbe:					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
the M	or 28 e noti	Dir	10e. Street and Number	-	10f. Zip Code		10	g. Citizen of What Co	
h with	nust b	Funeral	701 Furnace Street		21502			U.S.A.	
r deat	or iten niner r	by Fu	11. Marital Status 1 Never Married 2 Married 12. Was Decedent E-Armed Forces? 1 Yes 2 X	ver in U.S.	Was Decedent of Hispa If Yes, specify Cuban, N	nic Origin? (Spe lexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	
036	ıral", (Exan	ed p	3 Widowed 4 □ Divorced If Yes, Give Year or Dates.	10	1 ☐ Yes 2 💢 No S	pecify:		Specify: Wh	nite
15-C	ı "natı ledica	Completed	15. Decedent's Education (Specify only highest grade completed)	i (Gir	cedent's Usual Occupation we kind of work done durin	n ng most of worki	ing 10	6b. Kind of Business	Industry
212 within	giene. er thar the M		Elementary/Seconday (0-12) College (1-4 or 5-	+)	. DO NOT use retired) omemaker			Home	
nd	ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		18		e (First, Middle, Ma	,	
rya Elle be	n and Mental I 7 is marked raumatic eve		William Russell O'Neal 19a. Informant's Name/Relationship (Type, Print)	1			uise Sisl		
Baltimore, Maryland 21215-0036	alth an 27 is er trau		Janice Thom / Daughter		ailing Address (Street and a 205 Bedford				21502
ore,	If item or othe		20a. Method of Disposition 1	cemetery, c	sposition (Name of rematory or other place)	į į	ı	0c. Location - City or	
tim	ntant:		4 ☐ Donation 5 ☐ Other (Specify)		morial Park		/2011	Cumberla	*
Ba	Department of Health and Mental Important: If item 27 is marked any injury or other traumatic evonce.		21. Signature of Funeral Service License	(ne)	22. Name and Address of 202 Greene	Street	, Cumber	neral Home Land, MD	21502°
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not e	enter the mode of dying, su	uch as cardiac o	or respiratory arrest	,	Approximate Interval Between
	ysician, Medical	ì			R ACCIDENT				Onset and Death
	xaminer		Due to (or as a	consequence of):					
-	#	iner	cause. Enter Underlying	consequence of):					
ecuted	and I-trans	Examiner	Cause (Disease or iinjury that initiated events c	consequence of):					
68760 certificate be executed	physician and s the burial-transit	dical I	d						
6876 ertificate	ing phy	Med	IF FEMALE:					1	
	attendi for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	2 🗌 Fetal death 3	B			23d. Date of de Month	livery Day Year
P.O. Box that the death	ached	hysi	1 Yes 2 No 4 Pregnant at 9 Unknown 9 Unknown	time or death	DE Other (Specify)				
	gnec oe d	þ	Part II. Other significant conditions contributing to death but	it not resulting in the	e underlying cause given i	n Part I.		_/	the cause of death?
ords, requires	been s	Completed					1 LJ Yes		robably 4 Unknown
Reco	certificate has birector, page 2 sl	dwo					autopsy performe	prior to death?	completion of cause of
an: ⊞	rtificat tor, pa		25. Was case referred to medical examiner?		26. Place	of Death (Check	1 Yes 2 only one)	No 1 □ Yes	s 2 No
VIT	this ce al direc	욘	1 Yes 2 No Tospital: 1 Inpatie	nt 2 🗆 ER/Outpat		Nursing Ho	me 5 🗆 Residen	ce 6 Other (Spec	cify)
DIVISION OF VITAL RECORDS, Ial or Attending Physician; The law requires	th. After funera	Certificate:	27, Mann of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day)	y 28b. Time Year) injury	work?	2 🗆 No	28d. Describe how	injury occurred	
'ISIO	er dea re ctor: by the	ertifi	3 Suicide 6 Could not be	ry - At home, farm,	street, factory, office		28f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
oital o									
e Hos	e Fune	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of n 2 Medical Examiner: On the basis of ex 3 Certifying Nurse Practioner: To the basis of ex only one)	amination and/or inv	restigation, in my opinion, d	leath occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
- - 10 #	vithi.	_	29b. Signature and title of certifier		29c. License nur D1486	mber		Date signed (Month	h, Day, Year)
_	> - 0		= 17/1 //		1 DI400	, _		UUL. 20,	4011
			Colour Vous / 12	mily	<u> </u>				
	5		30. Name and address of person who completed cause of de Robustiano J. Barrera, Jr. 31. Date filed (Mon) 17 Year) 2011 32. Fegistrar		e, Print)	treet.	Cumberlar	nd. MD 21	.502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Day 201 Physician/ ERR DALTON 2:58PM Medical 4a. Facility Name (if not institution, give street and number) MEDICAC Examiner 4b. City, Town, or Location of Death 4c. County of Death MD UNIVERSITY OF MARYLAND BALTIMORE CENTE Baltimore Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months 1 🛛 M 2 🗆 F Hours Jul 5 1948 Country) 214-46-9960 **Director** 63 VA Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 19 Boyle Ct. 21911 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc 3 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", White Completed 3 Widowed 4 X Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Welder Amtrak Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Wilmer W. Dalton Ruth Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth B. Clutter/ Mother 23 Farragut Ct. Elkton, MD 21921 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/2372011 cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State R.T. Foard Funeral Home, P.A. 4 Donation 5 Other (Specify) Rising Sun, MD Signature of Funeral Service License Name and Address of Facility
T. Foard Funeral Home, P.A. S. Queen St. Rising Sun, 23a. Part 1. Enter the disease, or con shock, or heart failure. List only ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Physicians/ Medical Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of) ding physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy perform death? After this certificate 2 🗌 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one) ြို Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA the funeral Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work 24 hours after death. Funeral Director: A 2 🗌 No 2 "Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year

DHMH 17 Rev 7/2009

GREENE ST, BALTIMORE MD ZIZOI

completed cause of death (Item 23a) (Type, Print)

225

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELIZABETH IRENE EDWARDS (AKA) IRENE E. EDWARDS OCTOBER 2011 Medical 19:00 PM 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11 CURTIS DRIVE CECIL RISING SUN 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea. 9. Birthplace (State or Foreign CountrKLONDIKE MARYLAND **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 1 □ M 2 🟋F Days Min Hours 77 Director Yrs <u> 215–30–5604</u> 16,1934 FEB. 28a-f shov 10b. County with the Maryland Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director CECIL MARYLAND RISING SUN 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country' 23a Funeral 11 CURTIS DRIVE 21911 UNITED STATES items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc "natural", or þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🗓 No Specify: 3 Widowed 4 Divorced Specify: WHITE Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ith and Mental H
27 is marked of
raumatic ever SHERMAN EVERETT EWING ANNA D. MILLER Page 1 and 2 should I ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. GERALDINE LEWIS / DAUGHTER P.O. BOX 555, PILOT POINT, TEXAS 76258 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State OCTOBER 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 25, 2011 NORTH EAST, MARYLAND 21. Signature 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hearly failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final OFD Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated events or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the ate has been signed by the attending page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No 1 ☐ Live Birth
4 ☐ Pregnant a
9 ☐ Unknown Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy after death.

Director; After this certificate I 1 Yes 2 No 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide City or Town, State) To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 65902 60127 21 11

State Registrar 21921

Dr. Carlo Gopez, MD, 138 Cathedral Street, Elkton, Maryland

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 14 Month Kathryn Glanville Wanetia October 2011 1:45 Α Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Allegany Cumberland Golden Living Center If Under 1 Year If Under 24 Hrs. 5 Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 X F 84 Country) West 215-28-8873 Yrs Virginia Director Usual Residence of Decedent or 28a-f show 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Clearville PΑ Bedford 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with IISA 15535 729 Bear Gap Road 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify. 3 X Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d be filed within 72 Jental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Nurses' Aide 12 Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Westfall 2 Francis Oletia Ralph Scott Jackson 1 and 2 should be of Health and Mei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 776 West Stuckey Road, Artemas, PA Robin Miller / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Sunset Memorial Park 10/18/2011 20a. Method of Disposition 20c. Location - City or Town, State Department of I Important: If it any injury or of once. ō 1 X Burial 2 Cremation 3 Removal from State Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. gnatule of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Eller Underlying Cause (Disease or iinjury Due to (or as a consequence of) burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) in the past 12 months? ō Pregnant at time of death signed by the at Id be detached for Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ HYPERTENSION, Division of Vital Records, CEREBRO 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ACCIDENT has performed? Yes 2 No hin 24 hours after death.

the Funeral Director: After this certificate Impleted filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 ☐ No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manne Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one To t 29b. Signature and title of certifier 29c. License number D0054004 5

Registrar

DHMH 17 Rev 7/2009

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erson who completed cause of death

32. Registrar's Signature

Shiv C. Khanna, M.D.,

31. Date filed (Month, Day, Year) 0CT 17 2011

n 233 (Type, Print) 1221-E National Highway, LaVale, MD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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		for AMEND# State 10/2 Registrar	/2016 per 24/2011 2	FH State ACO HFALTH	of Ma जिस्ता	arylan ' OMH	d / Depa	artment : tificate :		lealth and N			7111	1 35	490
		1. Decedent's Name				(11	Cei	incate	OI L	eau i	2. Date of De				of Death
Physicia Medic		Dian		Marie		Gi1	kerson				Octobe	r 20	y, 2011	5:15	A M
Examin	er	4a. Facility Name (if South Riv	ver Hea	1th&Reha		enter		Edgew	ate			Ar.	County of D	ındel	
Funeral Director		5. Social Security N 214–86–08	03	6. Sex 1 M 2 XF	7. Age		st birthday) Yrs.	If Under 1 Months E	Year Days	Hours Min.	8. Date of Bir 05/08/1			Birthplace (Stat Country) SNINGTO	
ryland -f show ied at	ctor	Usual Residence of 10a. State Maryland	10b. County	Arundel			y, Town or Loc						<u></u>		City Limits
he Ma or 28a e notifi	Funeral Director	10e. Street and Nur		III under				10f. Zip Co	ode			10g. Ci	tizen of What		res 2 🗆 NO
s 23a	neral	144 Washi	ngton :	Road				210	037			Uni	ted St	ates	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 XNever Marr 3 ☐ Widowed		If Von C	Forceson s 2 🔼 Give	Ever in U.S No		Was Decedent Yes, specify		spanic Origin? (Spon, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)			American Indian, Vhite, etc. (hite	
2 hours "natur edical	plete	(Spe		nt's Education est grade complete			16a. Deced	lent's Usual C	Occupa done d	ation during most of work	ina	16b. k	ind of Busine	ess Industry	
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be filed w lental Hygi rked other tic event, I	To Be	17. Father's Name (ast)			onomp.			18. Mother's Nam Margaret			Surname)		
d 2 should alth and M 27 is ma er traumat		19a. Informant's Na Kenneth	ame/Relationsl Gi1ker	nip <i>(Type, Print)</i> son/Brotl	ner		19b. Mailir 240 I	ng Address (S Rainboy	treet a	nd Number or Run rive, #14	1 Route Number	er, City or ivin	Town, State gston,	TX 773	99
Page 1 an nent of He int: If item iry or othe		20a. Method of Disp 1 X Burial 2 4 □ Donation	☐ Cremation	3 ☐ Removal fro	m State	20b. P	lace of Dispo emetery, cren Linco	sition (Name natory or othe oln Cer	of er place met	10/25/ ery 11/0	2011 1 /2011			y or Town, State , Mary1	
permit. Departn Importa any inju		21. Signature of Fu	heral Service I	icensee						s of Facility Ge					
Physician/ Medical			rt failure. List o (Final	complications that only one cause on Due to	each line) .	moh'c			g, such as cardiac			9 20	Approxir Interval I Onset ar	Between
Examiner	ner	Sequentially list co	nmediate	b. Due to	o (or as a	a consequ	ence of);			·			<u> </u>		
e executed ian and urial-transit	Exami	cause. Enter Unde Cause (Disease or that initiated event resulting in death)	iinjury s	c	o (or as a	a consequ	ence of):							-	
cate be e physicia s the buri	edical		V	d											
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent in the past 12 i 1 Yes 2 9 Unknown	months?		re Birth egnant a		I death 3	Ectopic pre Other (spec		у			23d. Date of Month	f delivery Day	Year
ires that t signed by Id be deta	d by P	Part II. Other signif		ons contributing to			ulting in the u	nderlying cau	use giv	en in Part I.				te to the cause o	
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ian: Ti ertificat ctor, pa	Be C	25. Was case referre			Feeto				26. Pla	ace of Death (Chec		2 3 N	0 1	res 2 LINO	
Physic this ce	으	1 Yes 2 2	⅓ No	Hospital: 1 [28a. Dat		- T	ER/Outpatier			4 Mursing H				Specify)	
nding ath. r: After e funer	icate	1 Natural 2 Accident	5 Pendir	ng (Mo	onth, Day		injury	М 200.	. Injury work 1 🗆		28d. Describe	now inju	ry occurred		
al or Atte s after de il Director ed in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 28e. Plac		ury - At ho c. (Specify		eet, factory, o	ffice		28f. Location (City or Tox			r Rural Route No	ımber,
he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2	Medical E	Physician: To the xaminer: On the b Nurse Practione	asis of e	xamination	and/or invest	tigation, in my	opinio	n, death occurred a	t the time, date	and place	e, and due to	the cause(s) and	manner stated
To the with To the Com		29b. Signature and	title of certifier		. §	w	ono			number 0653				lonth, Day, Year)	01/
4-1		30. Name and addr		who completed ca Deale	1		23a) (Type, F	Print) G	yo	in C.	SUF	m	D	2075)
Stat Registra		31. Date filed (Mont	OCT 2	1 2011	Registra	ar's Signat	A. A	barke							

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month October 2011 РМ Brian Keith Grant 1645 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 124 Wilson Street Ceci1 Cecilton 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min 1 🕅 M 2 🗆 F Hours July 23, Maryland **Director** 216-80-7305 40 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Ceci1 Cecilton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 124 Wilson Street 21913 United States Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No lf Yes, Give Year or Dates. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. "natural", 3 Widowed 4 X Divorced Specify: Completed White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Construction Carpenter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John I. Grant Mae E. Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Serina Grant/Daughter 119 Hollingsworth Manor, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State cemetery, crematory or other place, ember 3 A. Ferris & Co., Inc. West Chester, PA Donation 5 D Other (Specify) Signa re of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached f Yes 2 No 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 X Yes 2 No 3 Probably 4 Unknown , certificate has been significator, page 2 should f 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 🔀 No Other: 1 🗌 Yes မ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 ื Natural 5 Pending 1 🗌 Yes 2 \square No the f Accident Investigation within 24 hours after deat To the Funeral Director; Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and the of certifier 0062190

DHMH 17 Rev 7/2009

State Registrar AUGUSTINE HERMAN HWY, SUITEA, CHESAFEAKECITY
MD 21915

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHAN

SHAHNAWA Z

31. Date filed (Month, Day, Year)

33

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiqqq 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Poures Month 11:45 PM **Physician** Ž Duice /Medical Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Residen Greenbelt Coeur Green belt Vince If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State of Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 20 F 96 Director 0ct 2, 1915 Yonkers, <u>578-28-2501</u> Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-1 show traumatic event, the Medical Examinar must be notified at 1,□Yes 2□No Directo Maryland | Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code with ö United States Items 23a 20706 Funeral 9885 Greenbelt Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. sm 27 Ia marked other than "natural", or Ite 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2€ No Specify: Specify: Black ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Ninth None Licensed Health Care Provider DC Government HHS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henry Patterson Stubbs Lottie May Wolfolk 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit, Pages 1 and 2 Department of Health a Important: If Item 27 Ia any injury or othar trau once. Areather T. Murray/Daughter 3305 Dunwood Ridge Terrace, Bowie, Maryland 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) November 2, Lincoln Memorial Suitland Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Murray Funeral Home, 1722 North Donald R. Gray Capital Street NW, Washington DC 20002 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complete ones that caused the shock, or heart failure. List only of cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** comp multiple Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner physician and s the burial-transit be executed F Due to (or as a consequence of) Box 68760 Physiclan/Medical The law requires that the death certificate use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day jo in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) Records, P.O. the detached 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ be 2 1 No 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Gustro es 2 No 2 🗹 No 1 Yes Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ᠿ No 2 ER/Outpatient 2 3□ DQA this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Man fer of Death 28b. Time of 28d. Describe how injury occurred Certification: After MA 1 Natural 5 Pending investigation MA 2 P No after death. М 1 Tyes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory office building, etc. (Specify) determined 24 hours after on Funeral Direct 4 Thomicide MA 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2011 MOS

Registrar

State

V

30. Name and address of person

31. Date filed (Month, Day, Year)

7

NOV 0

West

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#8,19a - State Registrar 10/21/11, M.S. Kent Co. Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 18, BETTY JEAN GUTTING 201 Tear 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HERON POINT CHESTERTOWN KENT Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday 8. Date of Birth _{ar)}1921 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F MARCH 24, Months Days Hours INDTANA Director 21 307-14-5861 90 Usual Residence of Decedent lan "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 □ No KENT MDCHESTERTOWN 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 221 HERON POINT UNITED STATES 21620 permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: WHITE 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည RUSSELL S. MORRIS HILDA GRAHAM 19a. Informant's Name/Relationship (Type, Print)
Sue Gutting/ Daughter-in-law
JCHN P. GUTTING/SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 451 WALNUT STREET CHURCH HILL, MARYLAND 21623 or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Find Important: If ite any injury or ot Date 1 Nurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) FORREST 11/05/2011 SHELBYVILLE, IN HILL 21. Signatere of Funeral Service Licer FELLOWS, HELFENBEIN & NEWNAM FUNERAL 130 SPEER ROAD CHESTERTOWN, MARYLAND P.A. 23a. Patt 1. Enter the disease, or complications that daused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ FAILURE THRIVE disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** SPINAL OSTEOPORUSIS Years if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and that initiated events Due to (or as a consequence of): resulting in death) Last the burialphysician Physician/Medical The law requires that the death certificate be Box 68760 attending p use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year signed by the a 9 Unknown P.0. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 : autopsy performed? 2 🔀 No 1 Tyes the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔀 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Division within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation M 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Sionature and 0

Registrar

DHMH 17 Rev 7/2009

State

MD

hestertown.

cause of death (Item 23a) (Type, Print)

32. Registra

11-08122

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible

my Tetteh Gri	ffin	1- For State	ate of Maryl		artment o		nd Ment	al Hyg	iene	2 (3549
Physic Medical Exam		1. Decedent's Name (First, Midd Amy	le,Last) Tetteh		ffin			2.	Date of Deat Month October 25	eg. No. h Day Y 9 2011	ear	3. Time of Death 1509 hrs
*		4a. Facility Name (if not institution 5800 Rayburn Drive	on, give street and n	umber)		4b. City, Town, o			30.000	4c. County Prince		
Funeral Director		5. Social Security Number 220-98-7444	6. Sex	7. Age (In yrs.	last birthday)		ear If Under	24Hrs. 8 Min.	3. Date of Birt		Foreig	thplace (State or on Maryland untry)
w any		Usual Residence of Decedent 10a. State 10b, County			y, Town or Locat							10d. Inside City Limits
ath with the Maryland items 23a nr 28a-f show tot be notified at once.	Director	Maryland Prince 10e. Street and Number 5800 Rayburn I				10f. Zip Code 20748			10	og. Citizen of V USA	/hat Cou	1 Yes 2 X No
Baltimore, MD 21215-0036 Permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Oppartment of Health and Mental Hygiens I will also there is a fire in the Maryland important. If item 27 is marked other than "natural", ar items 23a nr 28a-f she niprory ar other traumatic event, the Medical Examiner must be notified at once	neral D	11. Marital Status 1 Never Married 2 MM	12. Was De	cedent Ever in Uorces?		as Decedent of H				14. Rac	e - Ameri te, etc.	can Indian, Black,
ours after d atural", nr xaminer m	d by Fu	3 Widowed 4 Div	orced If Yes, Give Yes or Dates: cify only highest gra	ar	16a. Deceder	Yes 2 X N	ation (Give ki			Specify.	B1a	
0036 within 72 h jene.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		mployed		,		Family		ocate
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than "natic event, the Medical.	Be	17. Father's Name (First, Middle, Charles 19a. Informant's Name/Relations	Tetteh		10h Mailine	g Address (Stre	Earı	nesti	ne F	Maiden Surnam Roberts		7:- 0-1-)
ore, MD 2 ss 1 and 2 shou of Health and N If item 27 is ner traumatic	To	James Edward G				Rayburn	Drive,	, Tem			D 20	748
Baltimore, M permit. Pages I and 2 Department of Health Impurtant: If item 2 injury nr other traum		1 Burial 2 X Cremation 4 Donation 5 Other Sa	pecify:	om State	crematory or oth las Cre	nerplace) matory		11/4	/2011	Edgewa	ter,	Maryland
		21. Signature of Funeral Service	e /		61	lame and Addres	Hill I	Rd. C	xon Hi	i11, MD	207	45
Physician /Medical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	aSeizure		ler	——————————————————————————————————————	g, such as car	diac or res	spiratory arre	est, snock, or no	запт	Approximate Interval Between Onset and Death
	er	Sequentially list conditions, if any, leading to immediate	b	consequence of								
uted td ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o				-	_		-	
e exec cian ar irial - ti	edical	X UNPENDED	d AMENDED	23a,27,	per me,g	g922 12-	-14-11	sm		v		
Box 68760, e death certificate be the attending physical for use as the but	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Univ	1 Live b	ant at time of de	2 Fel	tal death 3 ner (Specify)	Ectopic p	pregnancy		23d. Date of Month	_	ay Year
s, P.O. Be irres that the de signed by the detached f	by Phy	Part II. Other significant conditi			resulting in the u	nderlying cause	given in Part	I.	23e. Did tob	(the cause of death?
cords aw requested that the peer that the peer	Completed							_	24a. Was a autops	n 24b. sy ned?	Were aut prior to c death?	opsy findings available ompletion of cause of
tal Rection: The certificate ector, page	Be Co	25. Was case referred to medical examiner?				26.Plac	e of Death (C			No 1	✓ Ye	s 2 No
n of Vit Jing Physic After this funeral dire	리	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 1 1 28a. Date (Month	npatient 2 of Injury	ER/Outpatient 28b. Time of Ir		Other 1 Nury at Work?			Residence 6		Scene
ision (Attending er death.	Certification:		ing tigation		ome, farm, stree		Yes 2 N		Location (St	treet and Numb	er or Rui	ral Route Number, City
Division To the Hospital or Attendin within 24 hours after death To the Funeral Director: A completely filled in by the fu	Certif	4 Homicide deter	d not be (Specify) ysician: To the bes						or Town, Sta	ate)		
To the E within 24	Medical	one) 2 Medical Exam	niner:On the basis of and manner s	of examination a		on, in my opinio	n, death occu			nd place, and	due to the	e cause(s)
./	2	29b. Signature and title of certifie	M. 2	16			se number .M.E.			29d. Date sign October 30		
4		30. Name and address of person Jack Titus MD. Dep	who completed caus uty Chief Medic	•	,	altimore Str	eet, Baltim	nore, MI	D 21223			
St Regist		31. Date filed (Month, Day, Year) NOV 0 7 2011	32. Re	gistrar's Signati	arked							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Ronald T. Hitchins Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Western MD Regional Medical Center Cumberland Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month Day Year **Director** Maryland 56 March 21, 1955 218-64-9308 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19619 Shaft Road SW Funeral U.S.A. 21532-72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 M Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Institution Correctional Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Mella Miller Thomas Hitchins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21532-Maryland Nora Hitchins 19619 Shaft Rd SW Frostburg 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunset Memorial Park October 21, 2011 Cumberland Maryland 21. Signature of Emeral Service Licensee 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 27 CARCINOMA *www.cian/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 / No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury 5 Pending Natural 24 hours after death. Funeral Director: At ☐ Accident Investigation the Suicide 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

only one) 29b. Signature and title of certifler

Name and address

-AMAN

2011

2

the

son who completed cause of teath (Item 23a) (Type, Print)

Registrar's Signature

2502

Sectifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ROOK

29c. License number

Rd

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Harold Stanley Hubbard 6:350 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death alis DURG 100mico DICE If Under 1 Year I If Under 24 Hrs cial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 X M 2 D F Hours Feb. To Year) 945 217-44-2206 Maryland 66 Director Usual Residence of Decedent and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Dorchester East New Market 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? by Funeral 3634 Ocean Gateway 21631 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) garment mfg. fabric cutter Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John L. Hubbard Evelyn Warfield permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Hubbard 3634 Ocean Gateway, East New Market, MD son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 10/28/11 Cambridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. nure of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death ASCVD Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** + ibnhalio Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director, After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician a be detached for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate har funeral director, page 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Cother (Specify) H Hospital 2□No ဂ 1 Tes 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Mannér of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred HS (Month, Day, Year) Natural Natural injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and litle of certifier License number 063199 10/22/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 EASTERN SHORE DR, SALISBURY MD, 21 804 YOGES OHRA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death George Marvin Hummel Physician/ () Motober Medical Facility Name (if not institution, give street and number)
Baltimore Washington Medical Center Town, or Location of Death Glen Burnie Examiner 4c. County of Death
Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 205–22–5505 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**XX**M 2 □ F March Day Months Days Hours 81 ^{Year)} 19<u>30</u> Director Pennsylvania Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Anne Arundel be notified Millersville 1 Yes 2XXNo 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 899 Cecil Avenue South items 23a 21108 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces' Black, White, etc. "natural", or Completed by 1 Never Married 2 Married 1XXYes If Yes, Give Maryland 21215-0036 Specify: White 1 ☐ Yes 2XX No Specify. 3 X Widowed 4 ☐ Divorced 1947-68 Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ummel Elementary/Seconday (0-12) College (1-4 or 5+) Staff Sergeant U.S. Air Force Be 17. Father's Name (First, Middle, Last)
Ludley Hummel 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Wilds ပ 1 and 2 should be f Health and Ments 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 42962 Appaloosa Trail Ct. Chantilly, Virgin James Stickler/stepson Chantilly, Virginia 20152 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town. State ₽ ± 6 Baltimore Crematory Department of Important: If any injury or once. 10/21/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) TFuneral Sy Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Interval Between Immediate Cause (Final Onset and Death yeirian neumonia disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 No 1 🗌 Yes Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 27. Man of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural (Month, Day, Year) 5 Pending 24 hours after death. Funeral Director; A 1 Tyes Accident Investigation filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1 Ger 30. Name and address of person who completed stuse of death (item 23a) (type, Print) 25/10 2016

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 35498 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HEIN 8:00 P M KATHLEEN OCTOBER 16, 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 107 DUTCHES ROAD CHESTERTOWN OUEEN ANNE'S 9. Birthplace (State or Foreign Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2**X**) F Days Hours Min (Month, Day, Year -28-1938 **Director** 164-32-0703 Usual Residence of Decedent Show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD QUEEN ANNE'S CHESTERTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 107 DUTCHESS RD. 21620 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo If Yes, specify Cuban, Mexican, Puerto Rican, etc., Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: WHITE Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Elementary/Seconday (0-12) 12 life, DO NOT use retired) and Mental Hygiene, is marked other than College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) should be file 2 CHESTER M. KERNS ELANOR TROUTMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If Item 27 is any injury or other trau ALLEN MANDEN HEIN, JR. 107 DUTCHESS RD. CHESTERTOWN, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Kremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) CHESAPEAKE CREMATION 10-17-2011 STEVENSVILLE, MARYLAND 22. Name and Address of Facility FELLOWS. HELFENBEIN 370 W. CYPRESS ST. N I & NEWNAM FUNERAL HOME, P.A. MILLINGTON, MARYLAND 21651 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ heim ors disease or condition resulting in death) Geave Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria by Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown signed by a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has ral director, page 2 performe 2 No Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 1 🗌 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 📈 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D0050996

Registrar
DHMH 17 Rev 7/2009

State

Rn

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Chestert aun MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Standard

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ ^{Day} 2011 OCT Veronica Doris Hickey 20 4:53 a^{M} Medical 4a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** 4c. County of Death Carrol1 Carroll Hospice Dove House Westminster Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth Days (Month, Day, Yea Months Hours Min. 1 🗆 M 2 🗑 Director 82 220-20-587 1929 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 Yes 2 XNo Carrol1 Taneytown Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 318 Butterfly Drive 21787 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian, Armed Forces? Black White etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White If Yes, Give Year or Dates 3 ₩ Widowed 4 Divorced Completed th and Mental Hygiene.
It is marked other than "natul traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Hom<u>emaker</u> Domestic 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Veronica Kleinsmith John V. Weber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
318 Butterfly Drive Taneytown, MD 21787 19a. Informant's Name/Relationship (Type, Print) 318 Butterfly Drive Herbert E. Hickey, Jr./son item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of I
Important: If ite
any injury or of 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 10/24/2011 Sykesville, MD Lake View Memorial Park 22. Name and Address of Facility Haight Funeral Home & Chape P.O. Box 195 Sykesville, M 21. Signature of Funeral Service Licen (410-795-1400) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death OBSTRUCTURE Physician Rumanary preside CHRONIC Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or de a consequence of, Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last as the burial-tran Due to (or as a consequence of) signed by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobasco use contribute to the cause of death? ģ page 2 should be 2 No 3 Probably 4 Unknown Completed Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed 2 🗌 No 1 🗌 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 D Other (Specify E DOVE HOO 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral funeral 28a. Date of injury Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' 1 Yes 2 No М Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Solid lying in Nystotian to the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WJZ 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21157 maryant I LTOM AS WYS TMINSTER it- GALVIN TYMO 291 STONER AVENCE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar Barker

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 35500 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month GRACE RAINE INGERSON OCTOBER 18:10 PM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death UNION HOSPITAL OF CECIL COUNTY ELKTON CECIL Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, MARCH 1 9. Birthplace (State or Foreign Country NORTH EAST MARYLAND **Funeral** 1 □ M 2 **X** F Days **Director** 219-14-2377 87 Usual Residence of Decedent show should be filed within 72 hours after death with the Maryland 10a, State 10b. County 10c, City, Town or Location must be notified at 10d. Inside City Limits Director or 28a-f XX Yes 2 No MARYLAND NORTH EAST CECIL 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 708 ELK RIVER MANOR 21901 UNITED STATES Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: WHITE "natural", 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filled within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES H. RAINE VERA C. NICKLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LONNIE DAVIS / SON 143 YELLOWFIELD BOULEVARD, ELKTON, MARYLAND 21921 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of OCTOBER. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) NORTHER STEET CEMETERY 22, 2011 NORTH EAST, MARYLAND 22. Name and Address of Facility CROUCH FUNERAL HOME, P.A. 127 SOUTH MAIN STREET, NORTH EAST, MARYLAND21901 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fail i.e. List only one cause on each line. Immediate Cause (Final Bawel Physician/ disease or condition resulting in death) Unknown Medical Examiner Sequentially list conditions, if any hearing to immediate cause. Enter Underlying Physician/Medical Examiner **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death bugnot resulting in the underlying cause given in Part I.

Chronic Obstructive full ways Jisewse 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 🗹 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical

Division of Vital Records, P.O. Box 68760

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gartifying Nurse Fractioner To the best of my hrowings of other 29b. Signature and title of prtifie 10.20.2011. Jachden Smir 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELKTON MD 21921. 126 A, E tich ST,

Registrar DHMH 17 Rev 7/2009